STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid abbreviated survey was conducted 11/12/19 through 11/13/19. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.

The census in this 120 certified bed facility was 117 at the time of the survey. The survey sample consisted of eight current resident reviews.

F 578 SS=D Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)

§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still

F 578

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.

F578

1) Resident #1 is exercising her right to refuse medication.

2) Current Residents have the potential to be affected.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cheryl Martin	Administrator	11/26/19

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 578	Continued From page 1	F 578		

legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to allow a resident to exercise the right to refuse medication for one of eight residents in the survey sample, Resident #1.

The facility staff failed to acknowledge Resident #1's right to refuse medication. LPN #3 administered Miralax (1), mixed in water, to Resident #1 after the resident stated she did not want the medication.

The findings include:

Resident #1 was admitted to the facility on 3/10/17. Resident #1's diagnoses included but were not limited to diabetes, major depressive disorder, breast cancer and macular degeneration (eye disease). Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference

3) DNS/Designee will complete medication administration observations and reeducation for medication administration guidelines for licensed nurses.

4) Medication observations will be completed for 3 licensed nurses per week for 8 weeks. DNS/Designee will review audits. Findings reported to QAPI committee monthly for further action if necessary.

5) Compliance Date: 12/3/2019

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F 578	Continued From page 2	F 578		

date) of 7/29/19, coded the resident as being cognitively intact.

On 11/12/19 at 2:00 p.m., an interview was conducted with Resident #1. The resident stated she was blind and could not see.

Review of Resident #1's clinical record revealed the following physician's orders (including but not limited to): 11/1/18 Miralax (4) 17 grams by mouth once a day.

On 11/13/19 at 10:30 a.m., LPN (licensed practical nurse) #3 was observed preparing Resident #8's medications (including but not limited to the above medication).

On 11/13/19 at 10:48 a.m., LPN (licensed practical nurse) #3 was observed administering medications to Resident #1. Miralax, mixed in water, in a cup with a straw was one of the medications. While administering the medications to Resident #1, LPN #1 told the resident she had her Metamucil and placed the cup of Miralax and water to the resident's mouth. Resident #1 took a sip from the straw and stated she did not want Miralax. LPN #3 told the resident to take another sip. Resident #1 took another sip from the straw and asked if the water contained Miralax. Resident #1 then stated I said I do not want Miralax. LPN #3 did not reply. LPN #3 walked back to the medication cart and obtained another pill for Resident #1. LPN #3 entered Resident #1's room and administered the pill with the remaining water containing Miralax. Resident #1 asked LPN #3 if the water contained Miralax and LPN #3 stated, "Yes." Resident #1 stated, "Don't give me anymore." LPN #3 discarded the remaining water containing Miralax.

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F 578 Continued From page 3 F 578

On 11/13/19 at 10:55 a.m., an interview was conducted with LPN #3. LPN #3 stated she usually works night shift and this was the second time she had worked day shift. LPN #3 was asked if a resident has the right to refuse medication. LPN #3 stated, "Yes." LPN #3 was made aware of the above observation. LPN #3 stated she did not realize Resident #1 had stated she did not want Miralax. LPN #3 was asked what she would have done if she realized Resident #1 stated she did not want Miralax. LPN #3 stated she does try to encourage residents to take their medications so she would ask the resident if she was sure then comply with the refusal after a second attempt.

On 11/13/19 at 2:45 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), LPN #1, ASM #3 (regional director of clinical services), ASM #4 (another regional director of clinical services) and ASM #5 (regional vice president) were made aware of the above concern.

On 11/13/19 at 4:30 p.m., ASM #3 stated the facility did not have a policy regarding the right to refuse medication.

No further information was presented prior to exit.

(1) Miralax is used to treat constipation. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a603032.html

F583

1) The healthcare providers, RN #1 and ASM #3 were reeducated on HIPPA and to

F 583 Personal Privacy/Confidentiality of Records F 583

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F 583 SS=D	Continued From page 4 CFR(s): 483.10(h)(1)-(3)(i)(ii)	F 583		

§483.10(h) Privacy and Confidentiality.
The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

§483.10(h)(i) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review it was determined facility staff

provide privacy for discussion of medical information.

2) Current Residents have the potential to be affected.

3) Social Services/ Designee will provide staff education on resident's rights to confidentiality and privacy of health information. Carekeeper rounds to monitor for compliance of residents privacy.

4) Carekeeper rounds to be reviewed by Administration/Designee in Morning Start up meeting for further action. Findings reported to QAPI committee monthly for further action if necessary.

5) Compliance Date: 12/3/2019

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failed to provide privacy for medical information for one of eight residents in the survey sample. On 11/12/19, two healthcare providers, RN (registered nurse) #1 and ASM (administrative staff member) #3 were observed in the main hallway of the facility and heard discussing Resident #7's medical information, with other staff members and residents present in the hallway.

The findings include:

Resident #7 was admitted to the facility on 11/12/2014 with a readmission on 11/11/2019. Resident #7's diagnoses included but were not limited to cellulitis (1) and dementia (2). Resident #7's most recent MDS (minimum data set), a thirty day assessment with an ARD (assessment reference date) of 09/25/19, coded Resident #7 as scoring a 6 (six) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 6- being severely impaired for making daily decisions.

On 11/12/19 at 12:10 p.m., an observation was made in the main hallway of the facility of ASM (administrative staff member) #6, nurse practitioner and RN (registered nurse) #1. ASM #6 was heard asking RN #1, "Why did [Name of Resident #7] not receive his antibiotic today?" RN #1 stated that the order did not come in from the pharmacy. ASM #6 stated that it appeared he had received a dose [antibitotic] yesterday evening and that it [antibiotic] should be in the building for him to get it today. ASM #6 and RN #1 proceeded to walk down the hallway continuing to discuss Resident #7's medication. Other staff including the dietary manager and other residents were observed in the hallway during the conversation.

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F 583	Continued From page 6	F 583		

Review of the POS (physician order summary) for Resident #7 on 11/11/2019 at 1:45 p.m. revealed "Linezolid (antibiotic to treat infection) Tablet 600 MG (milligram) Give 1 (one) tablet by mouth two times a day for cellulitis for 7 (seven) days. Order Date 1/11/2019; Start Date 11/11/2019; End Date 11/18/2019."

On 11/12/19 at approximately 2:30 p.m., an interview was conducted with RN (registered nurse) #1. When asked how privacy of resident information is maintained when discussing resident information with other healthcare providers, RN #1 stated that they talk in private. RN #1 was asked about the observation of the conversation between RN #1 and ASM #6, nurse practitioner regarding the Linezolid [antibiotic] not being available for Resident #7, on 11/12/19 at 12:10 p.m., in the main hallway of the facility with other staff including the dietary manager, two surveyors and other residents present. RN #1 stated that it did not promote privacy for Resident #7's information.

On 11/13/19 at 9:20 a.m., an interview was conducted with ASM (administrative staff member) #6, nurse practitioner. When asked how privacy of resident information is provided when discussing resident information with other healthcare providers, ASM #6 stated that staff do not talk in front of everyone else. ASM #6 stated that staff should adhere to HIPAA (Health Insurance Portability and Accountability Act) (3) and do not want to reveal any information without revealing who they are talking to. When asked the observation of the conversation on 11/12/19 at 12:10 p.m. of ASM #6 and RN #1 discussing the antibiotic treatment of Resident #7 while

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walking down the main hallway of the facility, ASM #6 stated that she should not have been discussing it in the hallway.

On 11/13/19 at approximately 1:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy for privacy of medical information.

On 11/13/19 at 4:30 p.m., ASM #3, the regional director of clinical services provided a document addressing "Confidentiality of Your Medical Information", "Personal Property and Funds" and "Facility Rules and Grievance Procedure." ASM #3 stated that the document was a page from the admission packet and that the facility did not have a policy regarding privacy of medical information.

The facility provided document "Confidentiality of Your Medical Information" documented "You have a right to confidential treatment of your medical information. Your confidentiality rights are described in our Notice of Privacy Practices, which is given to you upon admission ..."

On 11/13/19 at approximately 3:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, regional director of clinical services, ASM #5, regional vice president, and LPN (licensed practical nurse) #1, unit manager were made aware of the findings.

On 11/13/19 at 3:10 p.m., ASM #1, the administrator provided a copy of the document "Inservice/Meeting Summary" dated "11/12/19." It documented "All staff to include nursing management, MDs (medical doctors), NP (nurse

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practitioner), laundry, dietary, activities, rehab, maintenance are never to discuss resident issues names diagnosis in any area where information may be heard by other residents, family members visitors . All conversations regarding any resident is to be discussed in private." The document contained signatures from 27 staff members including ASM #6 and RN #1.

No further information was provided prior to exit.

References:

1. Cellulitis
A common skin infection caused by bacteria. It affects the middle layer of the skin (dermis) and the tissues below. Sometimes, muscle can be affected. This information was obtained from the website:
https://medlineplus.gov/ency/article/000855.htm.

2. Dementia
A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website:
https://medlineplus.gov/ency/article/000739.htm.

3. HIPAA
The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without

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4) ID EFIX AG	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 583	Continued From page 9 patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections. This information was obtained from the website: https://www.hhs.gov/hipaa/for-professionals/privacy/index.html	F 583		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:	F 585	F585 1) Resident #4's concern was resolved. A thorough search and inventory was conducted for Resident #4's missing items. Found items were labelled and documented. 2) Current Residents have the potential to be affected by untimely follow up of concerns. 3) Social Services/ Designee will provide staff and resident education on the facility's concern resolution process. 4) Administration/Designee to review any new concerns in Morning Start up meeting for further action. Findings	

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(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and

reported to QAPI committee monthly for further action if necessary.

5) Compliance Date: 12/3/2019

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as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and during the course of a complaint investigation, it was determined that the facility staff failed to resolve a grievance in a timely manner for one of eight residents in the survey sample, Resident #4. The facility staff failed to promptly address missing clothing for Resident #4 reported to OSM (other staff member) #5 (housekeeping and laundry manager) approximately 2 months prior to the date of the survey.

The findings include:

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Resident #4 was admitted to the facility on 4/13/2017 with a readmission on 01/20/2019. Resident #4's diagnoses included but were not limited to amyotrophic lateral sclerosis (1) and pneumonia (2). Resident #4's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/16/19, coded Resident #4 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15 being cognitively intact for making daily decisions.

On 11/12/19 at 1:55 p.m., an interview was conducted with Resident #4 regarding missing laundry items. Resident #4 stated that she has been missing eight shirts for more than two months. Resident #4 stated that she reported them missing to OSM (other staff member) #5, the laundry and housekeeping director several months ago. When asked if she has gotten any follow up on the missing shirts Resident #4 stated that OSM #5 keeps telling her that they are looking for them and giving her shirts that have not been claimed in the lost and found. Resident #4 stated that the shirt she currently had on was one that the staff had given her to wear that was not hers but she had taken it because it would fit her and hers were missing. Resident #4 stated that OSM #5 updated her last week that she was still looking for her shirts after she had asked to be updated about the investigation. When asked how she felt about her clothing items missing, Resident #4 stated that she was really mad and upset. Resident #4 stated that she does not have any family except a five year old who cannot buy her things and she has to do everything herself. Resident #4 stated that she knows that OSM #5, (the director of laundry and housekeeping) is new, but she feels has been patient with them.

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She stated she told OSM #5 about two months ago that she had the receipts from [Name of online retailer] for her missing clothing items and some day they will have to do more than just keep looking for them. Resident #4 stated that she knows that they are busy and have a lot to catch up on but she feels that she has given them sufficient time to catch up on things. Resident #4 stated that her name is in all of her clothing, that she ensures that it is put in everything. Resident #4 stated that her concern is for the eight shirts currently missing. Resident #4 stated she has voiced the concern multiple times to OSM #5 over the past months since OSM #5 has been in the position and has not gotten any response other than staff are looking for them and offering to give her someone else's clothes that no one claims.

On 11/12/19 at 6:40 p.m., an interview was conducted with OSM (other staff member) #2, the director of social services. When asked about the process staff follows when residents report missing laundry items, OSM #2 stated that whomever the resident reports the missing item to reports it to her and she fills out a concern form. When asked if she fills out a form whether the item is found or not, OSM #2 stated that she fills the form out for all concerns. OSM #2 stated when an item is missing staff check to see if the name [of the resident] was written in the clothing and whether or not the facility does the laundry. OSM #2 stated that the inventory sheet is checked to see if the item is accounted for. OSM #2 stated that laundry searches the closets of current residents and the laundry for the item. OSM #2 stated that if the item is not on the inventory list it is discussed with the administrator to see if reimbursement is an option. OSM #2 stated that the facility encourages residents and

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families to keep them informed of new clothing to keep the inventory list updated but many do not.

The facility provided "Grievance Tracking Log:2019" failed to evidence documentation of any grievances reported for missing clothing items reported by Resident #4.

On 11/13/19 at 7:45 a.m., an interview was conducted with OSM (other staff member) #5, housekeeping and laundry manager. When asked about the process staff follows for residents missing laundry items, OSM #5 stated that residents are encouraged to mark their laundry when they arrive whether it is washed at the facility or if their family does it. OSM #5 stated that if laundry is heavily soiled, it is sent to the laundry for infection control purposes either way. OSM #5 stated that if a resident's laundry comes to them with the label fading they revamp it to make the name more legible. OSM #5 stated that if they get laundry that is not labeled they hold it for thirty days in case it is reported missing. OSM #5 stated that when a resident reports their laundry item missing they get a description of the items that are missing and search to find a match for the items and then take to the resident for confirmation. OSM #5 stated that if they cannot find a match for the item they report it to social services who handles grievances. OSM #5 stated that they get all staff involved in searching the room for missing items. OSM #5 stated that if the item is not found they ask the resident to provide receipts and reimburse them for the missing items. When asked about the missing clothing for Resident #4, OSM #5 stated that the missing items were still being investigated. OSM #5 stated that Resident #4 was been offered items that were not claimed that would fit her,

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which she accepted. OSM #5 stated that some of the items reported missing, were found and returned to Resident #4 and that they were not labeled when found. OSM #5 stated that she was aware that Resident #4 was still missing two shirts bought through [Name of online retailer] and she was still looking for these. OSM #5 stated that they have found items previously in Resident #4's closet that it is very full. When asked about the typical period for investigating missing items, OSM #5 stated that they usually do a thirty-day search for missing items, then report back to the social worker. OSM #5 stated that she spoke with Resident #4 two days ago and advised her that they were still looking for the two shirts. OSM #5 stated that the social worker was aware that she was still looking for these and that Resident #4 had not been reimbursed yet for these items. When asked how long she had been looking for the missing shirts, OSM #5 stated a couple of months.

On 11/13/19 at 8:55 a.m., an interview was conducted with LPN (licensed practical nurse) #1, unit manager. When asked about the process staff follows for resident or responsible party grievances, LPN #1 stated that the grievances are taken by anyone and then reported to social services who completes the form and forwards to whoever the grievance affects.

On 11/12/19 at 5:30 p.m., an interview was conducted with CNA (certified nursing assistant) #3. When asked about the process staff follows for laundry at the facility, CNA #3 stated that the laundry done at the facility for residents, and is returned and placed in the drawers in resident rooms by the laundry staff. When asked what is done if another residents clothes are found in a

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residents drawer, CNA #3 stated that they are placed in the laundry to wash and return to the correct resident. When asked about the process staff follows for lost laundry, CNA #3 stated that staff look for the laundry and if not found it is reported to social services.

On 11/13/2019 at 12:45 p.m., ASM (administrative staff member) #1, the administrator stated that she has no documentation that Resident #4 has reported missing clothing documented though social services. ASM #1 stated that she had confirmed with the director of social services that there were no active grievances for Resident #4 regarding missing laundry items.

On 11/13/19 at approximately 1:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy for grievance procedures.

On 11/13/19 at 4:30 p.m., ASM #3, the regional director of clinical services provided a document addressing "Confidentiality of Your Medical Information", "Personal Property and Funds" and "Facility Rules and Grievance Procedure." ASM #3 stated that the document was a page from the admission packet and that the facility did not have a policy regarding grievance procedures.

The facility provided document "Facility Rules and Grievance Procedure" documented " ...The Facility grievance procedure for resolution of resident complaints in included in Notices given to you upon admission and also is available upon request."

On 11/13/19 at approximately 3:00 p.m., ASM

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(administrative staff member) #1, the administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, regional director of clinical services, ASM #5, regional vice president, and LPN (licensed practical nurse) #1, unit manager were made aware of the findings.

On 11/13/19 at 4:00 p.m., OSM (other staff member) #5, the laundry and housekeeping director stated that she and three other staff members went to Resident #4's room and searched her closet. OSM #5 stated that they went through each piece of clothing and found many of the missing items of clothing reported by Resident #4. OSM #5 stated that Resident #4 told them a particular resident had some of her clothing, which was checked, and nothing was found. OSM #5 stated that the laundry lost and found was checked where a top was found that was a different color than what she described but Resident #4 stated that she would take it. OSM #5 stated that a new inventory was made and Resident #4 verbalized satisfaction at the outcome.

No further information was provided prior to exit.

Complaint Deficiency

References:

1. Amyotrophic lateral sclerosis
Amyotrophic lateral sclerosis (ALS) is a nervous system disease that attacks nerve cells called neurons in your brain and spinal cord. These neurons transmit messages from your brain and spinal cord to your voluntary muscles - the ones you can control, like in your arms and legs. At

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F 585	Continued From page 18 first, this causes mild muscle problems. Some people notice -Trouble walking or running -Trouble writing -Speech problems. Eventually, you lose your strength and cannot move. When muscles in your chest fail, you cannot breathe. A breathing machine can help, but most people with ALS die from respiratory failure. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=als&_ga=2.187101664.955015671.1574007980-1838772440.1562936034 2. Pneumonia An infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia. You can also get pneumonia by inhaling a liquid or chemical. This information was obtained from the website: https://medlineplus.gov/pneumonia.html.	F 585		
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	F 656	F656 1) Resident #3s care plan is being implemented. 2) Audit of current Residents with catheters comprehensive care plans to ensure implementation. 3) Licensed staff will be re-educated on implementing care plans. 4) DNS/Designee will observe medication and treatment for 3 licensed nurses per week for 8 weeks. Findings reported to QAPI committee monthly for further action if necessary. 5) Compliance Date: 12/3/2019	

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required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, review of facility documentation and during the course of a complaint investigation, the facility staff failed to implement the comprehensive care plan for one of eight residents in the survey sample, Resident #3. The facility staff failed to implement the care plan regarding catheterization of for Resident #3.

The findings include:

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Resident #3 was admitted to the facility on 04/17/2018, with a readmission on 08/18/2019 with diagnoses that included but were not limited to urinary retention (1) and benign prostatic hyperplasia (2).

Resident #3's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 08/29/19, coded Resident #3 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions.

The comprehensive care plan documented, "Alteration in elimination of bowel and bladder history of UTI's (urinary tract infections), stress incontinence, constipation, in and out straight cath (catheterization) twice daily due to urinary retention. Date Initiated: 04/26/2018." Under "Interventions" it documented, "Catheterize as ordered. Date Initiated 08/10/2019. Revision on 09/28/2019."

On 11/12/19 at approximately 12:45 p.m., an interview was conducted with Resident #3. When asked about the catheterization procedures the staff provide to him, Resident #3 stated that a couple of months ago he had to complain to the staff because he was not getting the catheterization on the day shift. Resident #3 stated that it has gotten better since he complained; he stated that his sister met with the staff and they worked out a better schedule so it does not interfere with meals or activities and the nurses have time to do it. Resident #3 stated that it makes him angry that he has to complain to get the care that he needs; he feels that there is a communication gap between staff at the facility

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and they need to work on it.

The facility provided document titled "Grievance Tracking Log:2019" documented for Resident #3, "Received 8/12/19, Resident and sister reported the following concerns missed and or late catheterizations, communication between staff and other resident behaviors in main dining room." It further documented, "Resolved 8/15/19, Resolution; Meeting held with IDT (interdisciplinary team) and concerns discussed. Residents cathettorzations [sic] to be done at 10a and 10p per resident request. Staff education to be done with staff on communication and explanation to resident and family on how to file a concern and where the forms are located. Observation to be done in dinning [sic] room." "Follow up, Satisfied with resolution; Resident and sister seemed satisfied with what was discussed in meeting and the follow up from facility."

The POS (physician order summary) dated "Nov (November) 12, 2019" documented, "Straight cath 10am and 10pm. Two times a day for urine retention. Order Date: 09/06/2019. Start Date: 09/06/2019."

The MAR (medication administration record) dated "10/1/2019-10/31/2019" documented, "Straight cath 10am and 10pm. Two times a day for urine retention, Order Date: 09/06/2019 1807 (6:07 p.m.)" The documentation box for the date 10/16/19 "1000 (10:00 a.m.)" documented the following "7 [Initials of LPN #2]." The MAR further documented under "Chart Codes/Follow up Codes" the following, "7=other/See Nurse Notes."

The progress note "10/16/19 09:28 (9:28 a.m.) eMAR (electronic medication administration note)

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Note Text: Straight cath 10am and 10pm. Two times a day for urine retention. No catheter insertion kits available."

The MAR dated "11/1/2019-11/30/2019" documented the order as above. The documentation boxes for the dates 11/6/19 "1000 (10:00 a.m.)" and 11/9/19 "1000 (10:00 a.m.)" were observed to be blank.

Review of the progress notes for Resident #3 for 11/6/19 and 11/9/19 failed to evidence documentation regarding catheterization for the scheduled 10am procedure.

On 11/13/19 at 1:30 p.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked about Resident #3's catheterization schedule, LPN #2 stated that it [catheterization] is scheduled for 10:00 am and 10:00 pm and that schedule is not working very well. LPN #2 stated that often-Resident #3 is in activities or the nurses are finishing morning medications and the catheterization has to be done later in the day. LPN #2 stated that the schedule was going to be discussed with the physician and Resident #3 to see what will be best. When asked how the catheters for Resident #3 are obtained, LPN #2 stated that the residents get them through their insurance company now and they are stocked in the room. LPN #2 stated that they just started this process and they used to run out of them before they started this process. LPN #2 stated that when the catheter kits were not available they would pull the supplies individually but at times did not have the sterile gloves needed for the procedure. When asked about the scheduled catheterization on 10/16/19 documented as "no catheter insertion kits available", LPN #2 stated

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that he thinks that there were no sterile gloves available to perform the procedure. When asked what was done when staff did not have the supplies needed, LPN #2 stated that he talked to Resident #3 and explained that it was a temporary issue and Resident #3 was fine with waiting. LPN #2 stated that he assessed Resident #3 for bladder distention and made sure he was urinating without problems. When asked if he notified anyone that the catheterization was not performed as directed, LPN #2 stated that he did not; LPN #2 stated that he did have a phone list and could have contacted the registered nurse in the building or a unit manager by phone. LPN #2 stated, "If it's not there, it's not there." When asked what blank boxes on the MAR (medication administration record) mean, LPN #2 stated that they mean the procedure was not signed off as completed. When asked if it can be determined if the catheterization was performed if the MAR has boxes, LPN #2 stated no because there is no documentation. When asked if staff should document on the MAR when the catheterization was refused, or performed late, LPN #2 stated, "Yes, there are codes to put on there." When asked the purpose of the care plan, LPN #2 stated it is a guide to show the best way, to care for the residents efficiently. When asked if catheterizing Resident #3 is a part of his care plan, LPN #2 stated that it is. When asked if staff are implementing the comprehensive care plan when they do not catheterize the resident as ordered, LPN #2 stated, "No."

On 11/13/19 at 8:55 a.m., an interview was conducted with LPN (licensed practical nurse) #1, unit manager. When asked the process for keeping catheters on the units LPN #1 stated that overnight delivery is available if needed and they

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can call a local supplier to get a shipment. When asked about Resident #3's catheters LPN #1 stated that his catheters come from a different manufacturer now because his insurance covers the supplies and he should not run out of them. LPN #1 stated that sometimes Resident #3 is at breakfast or activities during the scheduled time for the catheterization and it is done later at his request or if an emergency comes up and it is late due to that. LPN #1 stated that the catheterization kits for Resident #3 are in his room and extra catheters are in the supply closets. LPN #1 stated that central supply is at the facility during the day and someone is available on the weekends to get something as needed. LPN #1 reviewed the progress note dated 10/16/19 documenting "no catheter insertion kits available" and stated that if no kits are available the supplies in the kits are separate and available for staff to get individually in the supply closet. When asked if there have been times when the catheterization was not done as care planned and ordered, LPN #1 stated that there have been a few times when he has not received the catheterization and the staff were educated. LPN #1 stated that the staff have met with the family and discussed the catheterization scheduled and all staff has been educated on it. When asked why Resident #3 has the order to perform straight catheterization twice a day, LPN #1 stated that he has BPH (benign prostatic hyperplasia) with urinary retention. When asked about the purpose of the comprehensive care plan, LPN #1 stated it is a guideline to go by to care for the resident. When asked if staff not catheterizing the resident as ordered and care planned is following the care plan, LPN #1 stated it is not.

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On 11/13/19 at approximately 2:30 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy regarding implementing the care plan.

On 11/13/19 at 4:30 p.m., ASM #3, the regional director of clinical services provided a document "4.7 The RAI (resident assessment instrument) and Care Planning, October 2016." ASM #3 stated that the document was the only guidance they had on implementing the care plan. ASM #3 stated that the facility uses their policies and Lippincott as their standard of practice.

A review of the facility provided document, "4.7 The RAI and Care Planning, October 2016" documented in part, "The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving ..."

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

On 11/13/19 at approximately 3:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4,

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regional director of clinical services, ASM #5, regional vice president, and LPN (licensed practical nurse) #1, unit manager were made aware of the findings.

No further information was presented prior to exit.

Complaint Deficiency

References:

1. Urinary retention-
Urinary retention is the inability to empty the bladder completely. Urinary retention can be acute or chronic. Acute urinary retention happens suddenly and lasts only a short time. People with acute urinary retention cannot urinate at all, even though they have a full bladder. Acute urinary retention, a potentially life-threatening medical condition, requires immediate emergency treatment. Acute urinary retention can cause great discomfort or pain. This information was obtained from the website: https://www.niddk.nih.gov/health-information/urologic-diseases/urinary-retention#sec1

2. Benign prostatic hyperplasia-
An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

F 658 SS=D — Services Provided Meet Professional Standards
CFR(s): 483.21(b)(3)(i) — F 658

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

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(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, clinical record review, and in the course of complaint investigation, it was determined that the facility staff failed to follow professional standards of quality for two of eight residents in the survey sample, Residents #1 and #8. The facility staff failed to administer Resident #1's morning medications in a timely manner on 11/13/19. The facility staff and failed to administer Resident #8's morning medications in a timely manner and failed to explain the type of medications administered to Resident #8 on 11/12/19. The facility staff failed to clarify a physician's order to include the dose of Vitamin D (1) that was to be administered to Resident #8.

The findings include:

1. Resident #1 was admitted to the facility on 3/10/17. Resident #1's diagnoses included but were not limited to diabetes, major depressive disorder and breast cancer. Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/29/19, coded the resident as being cognitively intact.

Review of Resident #1's clinical record revealed the following physician's orders (including but not limited to):
- 3/17/19 Aspirin (1) 81 mg (milligrams) by mouth once a day.
-3/20/19 Lasix (2) 20 mg by mouth once a day.
-2/1/19 Metoprolol (3) 150 mg by mouth once a day.

F658

1) Resident #1 and Resident #8 untimely medication administration was noted during observation with no adverse effect and MD made aware. Resident #8's dose for Vitamin D was corrected. Resident experienced no noted side effects and MD made aware. Identified license nurse has been reeducated regarding medication administration guidelines.

2) 100% audit of residents ordered Vitamin D to ensure dose. All residents have the potential to receive untimely medications.

3) DNS/Designee will complete medication administration competencies and education for medication administration guidelines for nurses and inputting medication orders with doses.

)EPARTMENT OF HEALTH AND HUMAN SERVICES
:ENTERS FOR MEDICARE & MEDICAID SERVICES

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F 658	Continued From page 28	F 658	4) Medication pass audits will be completed for 3 licensed nurses per week for 8 weeks. New orders will be reviewed in clinical start-up. Findings reported to QAPI committee monthly for further action if necessary. 5) Compliance Date: 12/3/2019	

-11/1/18 Miralax (4) 17 grams by mouth once a day.
-3/13/19 Mucinex (5) 600 mg by mouth once a day.
-10/30/18 Multivitamin, one tablet by mouth once a day.
-10/30/18 Pepcid (6) 20 mg by mouth once a day.
-10/30/18 Senna plus (7) 8.6/50 mg- two tablets by mouth twice a day.
-2/14/19 Vitamin C (8) 500 mg by mouth once a day.

Review of Resident #1's November 2019 MAR (medication administration record) revealed the above medications were due at 9:00 a.m.

On 11/13/19 at 10:30 a.m., LPN (licensed practical nurse) #3 was observed preparing Resident #8's medications (including but not limited to the above medications). On 11/3/19 at 10:48 a.m., LPN #3 administered the medications to the resident.

On 11/13/19 at 9:14 a.m., an interview was conducted with LPN #1 (unit manager). LPN #1 stated the facility staff follows the facility policies and Lippincott as standards of practice. LPN #1 was asked what time medications should be administered if they are scheduled at 9:00 a.m. LPN #1 stated medications should be administered within one hour before and one hour after they are scheduled but as close to 9:00 a.m. as possible. When asked if this is a standard of practice for care, LPN #1 confirmed it is.

On 11/13/19 at 10:55 a.m., an interview was conducted with LPN #3. When asked what time medications should be administered if they are scheduled for 9:00 a.m. LPN #3 stated

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medications should be administered within one hour before and one hour after the scheduled time. LPN #3 stated she usually works night shift and this was her second time working day shift so she was" slowed down."

Resident #1's comprehensive care plan dated 3/10/17 failed to document specific information regarding medication administration timing.

On 11/13/19 at 2:45 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), LPN #1, ASM #3 (regional director of clinical services), ASM #4 (another regional director of clinical services) and ASM #5 (regional vice president) were made aware of the above concern.

The facility/pharmacy policy regarding medication administration documented, "14. Medications are administered within 60 minutes of scheduled time..."

No further information was presented prior to exit.

COMPLAINT DEFICIENCY

References:
(1) Aspirin is used for heart attack prevention. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682878.html

(2) Lasix is used to treat high blood pressure and swelling. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682858.html

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(3) Metoprolol is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682864.html

(4) Miralax is used to treat constipation. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a603032.html

(5) Mucinex is used to treat chest congestion. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682494.html

(6) Pepcid is used to treat stomach ulcers. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a687011.html

(7) Senna plus is used to treat constipation. This information was obtained from the website: https://medlineplus.gov/druginfo/natural/652.html

(8) Vitamin C helps the body absorb iron and promotes healing. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=vitamin+c&_ga=2.135138161.1544439906.1574079558-1667741437.1550160688

2. a. The facility staff failed to administer Resident #8's morning medications in a timely manner on 11/12/19.

Resident #8 was admitted to the facility on

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7/15/19. Resident #8's diagnoses included but were not limited to stroke, diabetes and high blood pressure. Resident #8's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/18/19, coded the resident's cognitive skills for daily decision making as modified independence (some difficulty in new situations only).

Review of Resident #8's clinical record revealed the following physician's orders:
-7/15/19 Aspirin (1) 81 mg (milligrams) by mouth once a day.
-7/15/19 Folic acid (2) 0.8 mg by mouth once a day.
-7/15/19 Lisinopril (3) 20 mg by mouth once a day.
-7/24/19 Multivitamin one tablet by mouth once a day.
-11/5/19 Potassium Chloride (4) 20 meq (milliequivalents) by mouth once a day every Tuesday, Thursday, Saturday and Sunday.
-7/15/19 Sertraline (5) 50 mg by mouth once a day.
-7/15/19 Vitamin B12 (6) 1000 (micrograms) by mouth once a day.
- 7/15/19 Vitamin D (7) (no dose) one tablet by mouth once a day.
-7/15/19 Colace (8) 100 mg by mouth twice a day.
-7/15/19 Metoprolol tartrate (9) 50 mg by mouth twice a day.

Review of Resident #8's November 2019 MAR (medication administration record) revealed the above medications were due at 9:00 a.m.

On 11/12/19 at 11:03 a.m., LPN (licensed practical nurse) #4 was observed preparing and administering the above medications to Resident

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#8. LPN #4 failed to explain the type of medications or the reason they were prescribed to the resident.

On 11/12/19 at 4:25 p.m., an interview was conducted with LPN #4. When asked what time medications should be administered if they are scheduled at 9:00 a.m., LPN #4 stated medications should be administered within one hour before or one hour after the scheduled time. LPN #4 stated on this morning, she had begun her shift on a medication cart on the other unit but then found out she was supposed to be on this unit and did not begin administering medications on Resident #8's unit until 8:30 a.m. LPN #4 confirmed she did not administer Resident #8's medications until after 11:00 a.m. although they were due at 9:00 a.m. LPN #4 was asked what information nurses should provide residents when administering medications. LPN #4 stated she just tells the residents she is giving them their morning medications. LPN #4 stated certain residents ask what medications are in the cup so she identifies those medications and tells those residents what the medications are. LPN #4 stated she only does this for residents who ask.

On 11/13/19 at 9:14 a.m., an interview was conducted with LPN #1 (unit manager). LPN #1 stated the facility staff follows the facility policies and Lippincott as standards of practice. When asked what time medications should be administered if they are scheduled at 9:00 a.m., LPN #1 stated medications should be administered within one hour before and one hour after they are scheduled but as close to 9:00 a.m. as possible. LPN #1 was asked what information nurses should provide resident when

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administering medications. LPN #1 stated nurses should tell what medications they are giving and what the medications are for, even for residents who don't specifically ask. When asked if these are standards of practice for care, LPN #1 confirmed they were.

Resident #8's comprehensive care plan dated 7/18/19 failed to document specific information regarding medication administration timing.

On 11/13/19 at 2:45 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), LPN #1, ASM #3 (regional director of clinical services), ASM #4 (another regional director of clinical services) and ASM #5 (regional vice president) were made aware of the above concern.

The facility/pharmacy policy regarding medication administration documented, "14. Medications are administered within 60 minutes of scheduled time..."

The facility/pharmacy policy regarding medication administration documented, "13. Explain to resident the type of medication being administered and the procedure..."

No further information was presented prior to exit.

COMPLAINT DEFICIENCY

References:
(1) Aspirin is used for heart attack prevention. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682878.html

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(2) Folic acid helps the body make healthy new cells. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=folic+acid&_ga=2.31812734.1544439906.1574079558-1667741437.1550160688

(3) Lisinopril is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a692051.html

(4) Potassium chloride is necessary for the normal functioning of muscles, nerves and cells. This information was obtained from the website: https://www.merckmanuals.com/home/hormonal-and-metabolic-disorders/electrolyte-balance/overview-of-potassium-s-role-in-the-body

(5) Sertraline is used to treat depression. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697048.html

(6) Vitamin B12 helps in the formation of red blood cells. This information was obtained from the website: https://medlineplus.gov/ency/article/002403.htm

(7) Vitamin D helps the body absorb calcium. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=vitamin+d&_ga=2.202205649.1544439906.1574079558-1667741437.1550160688

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(8) Colace is used to relieve constipation. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601113.html

(9) Metoprolol tartrate is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682864.html

2.b. The facility staff failed to clarify a physician's order to include the dose of Vitamin D (1) that was to be administered to Resident #8.

Review of Resident #8's clinical record revealed a physician's order dated 7/15/19 for Vitamin D, one tablet by mouth once a day. The order failed to include a documented dose for administration.

On 11/12/19 at 11:03 a.m., LPN (licensed practical nurse) #4 was observed administering multiple medications, including 1,000 units of Vitamin D to Resident #8.

On 11/13/19 at 9:14 a.m., an interview was conducted with LPN #1 (unit manager). LPN #1 stated the facility staff follows the facility policies and Lippincott as standards of practice. LPN #1 stated medication orders should contain the medication name, dosage and how many times the medication should be administered. LPN #1 was asked what should be done if a medication order does not contain a dose. LPN #1 stated, "Then you should automatically stop and have it clarified."

Resident #8's comprehensive care plan dated

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F 658	Continued From page 36 7/18/19 failed to document specific information regarding medication dosage. On 11/13/19 at 2:45 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), LPN #1, ASM #3 (regional director of clinical services), ASM #4 (another regional director of clinical services) and ASM #5 (regional vice president) were made aware of the above concern. The facility/pharmacy policy regarding medication administration documented, "If necessary, the nurse contacts the prescriber for clarification..." No further information was presented prior to exit. Reference: (1) Vitamin D helps the body absorb calcium. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=vitamin+d&_ga=2.202205649.1544439906.1574079558-1667741437.1550160688	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and in the course of complaint investigation, it was determined that the facility staff failed to provide adequate ADL	F 677	F677 1) Resident #1 is receiving ADL care. 2) Current Residents have the potential to be affected. 3) DNS/Designee will provide education for performance guidelines for aides on ADL's expectations.	

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F 677	Continued From page 37	F 677	4) Administration/Designee to audit ADL documentation in Clinical Start up meeting for further action. Findings reported to QAPI committee monthly for further action if necessary. 5) Compliance Date: 12/3/2019	

(activities of daily living) care for one of eight residents in the survey sample, Resident #1. The facility staff failed to assist Resident #1 with personal hygiene (including face washing and teeth brushing) each day in April 2019 and September 2019.

The findings include:

Resident #1 was admitted to the facility on 3/10/17. Resident #1's diagnoses included but were not limited to diabetes, major depressive disorder and breast cancer. Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/29/19, coded the resident as being cognitively intact. Section G coded Resident #1 as requiring extensive assistance of one staff with personal hygiene.

Resident #1's comprehensive care plan dated 3/27/17 documented, "I have a physical functioning deficit related to: Mobility impairment, Self-care impairment..."

On 11/12/19 at 2:00 p.m., an interview was conducted with Resident #1. Resident #1 voiced concern that the facility staff is supposed to wash her face and assist her with brushing her teeth but that doesn't always happen.

Review of Resident #1's April 2019 ADL documentation failed to reveal evidence that the resident was assisted with personal hygiene (or refused care) on 4/8/19, 4/15/19 and 4/23/19. Review of Resident #1's September 2019 ADL documentation failed to reveal evidence that the resident was assisted with personal hygiene (or refused care) on 9/17/19, 9/14/19, 9/15/19 and

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\TEMENT OF DEFICIENCIES) PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 677	Continued From page 38 9/27/19. On 11/13/19 at 3:30 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated CNAs should provide personal hygiene care, including face washing and teeth brushing in the morning, after each meal, and at night. CNA #1 stated the CNAs evidence this care is provided by documenting on the ADL forms in the computer system. CNA #1 was asked if CNAs could prove care is provided if it is not documented. CNA #1 stated, "If I didn't chart on it, how can you know I did it?" On 11/13/19 at 3:54 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. A policy regarding ADLs was requested. No further information was presented prior to exit.	F 677		
F 684 SS=D	COMPLAINT DEFICIENCY Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and in the course of a complaint investigation it	F 684	F684 1) Resident #1 is receiving medications as ordered. MD has been made aware of missed dose with no negative outcomes related to not receiving one dose. 2) Current Residents with antibiotic orders have the potential to be affected.	

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\TEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 39	F 684	3) DNS/Designee will complete medication administration observations and education for medication administration guidelines for nurses and medications available in the STAT box. 4) Medication administration records will be reviewed in clinical start up by DNS/Designee. Findings reported to QAPI committee monthly for further action if necessary. 5) Compliance Date: 12/3/2019	

was determined that the facility staff failed to provide treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan for one of eight residents in the survey sample. The facility staff failed to administer Resident #1's prescribed antibiotic as ordered on 10/7/18 and the medication was available in the facility's stock medication supply.

The findings include:

The facility staff failed provide pharmacy services for Resident #1 for orders for Rocephin (antibiotic medication to treat infection) which was not administered as ordered on 10/07/2018 at 12:24 p.m. and was available in the facility's stock medication supply.

Resident #1 was admitted to the facility on 3/10/2017 with a readmission on 2/1/2019. Resident #1's diagnoses included but were not limited to diabetes (1) and dementia (2). Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/29/19, coded Resident #1 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions.

Review of the POS (physician order summary) for Resident #1 documented the following "Rocephin Solution Reconstituted 1 GM (gram) Inject 1 gram intramuscularly (into the muscle) one time a day for UTI (urinary tract infection) until 10/09/2018 23:59. Order Date 10/07/2018; Start Date 10/08/2018; End Date 10/09/2018."

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The facility "[Name of Facility] Antibiotic Box South Set" stock list documented the following, "Ceftriaxone 1g (Rocephin) QTY (Quantity) Exp. (expiration) Date 02-20 (February 2020)."

Review of the MAR (Medication Administration Record) for Resident #1 for "10/1/2018-10/31/2018" documented the medication as listed above. In the areas on the MAR for 10/8/19 "0900 (9:00 a.m.) and 10/9/19 0900" it was observed that the boxes were blank.

On 11/13/19 at 11:20 a.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked what it done if an ordered medication does not come in as expected, LPN #3 stated that staff should call the provider to see if it should be substituted with something else or if it is all right to hold it or not give it. LPN #3 stated that if it is something that is needed right away there have a backup pharmacy to use. When asked if an antibiotic is ordered in the afternoon would it be available from pharmacy to be given the next morning, LPN #3 stated that it should arrive the next day, if not staff should contact the doctor to see if something else should be used.

On 11/13/19 at 1:30 p.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked if an antibiotic is ordered in the afternoon would it be available from pharmacy to be given the next morning LPN #3 stated that it should arrive the next day, if not staff should contact the doctor to see if something else should be used. LPN #2 reviewed the MAR for Resident #1 for "10/1/2018-10/31/2018" which documented the medication as listed above. LPN #2 stated that the Rocephin should have been available to

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be given on the date 10/8/19 0900 (9:00 a.m.). When asked what blank boxes on the MAR (medication administration record) mean LPN #2 stated that they mean the medication was not signed off as administered. When asked if it can be determined if the medication was given by the MAR with the blank boxes, LPN #2 stated that it could not because there is not documentation. LPN #2 stated that you cannot prove that it was done if it is not documented.

On 11/13/19 at approximately 1:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy for placing medication orders to pharmacy.

The facility policy "Medication Administration General Guidelines, 09/18" documented in part "If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (for example, the resident is not in the nursing care center at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN (as needed) documentation. If two consecutive doses of a vital medication are withheld or refused, the physician is notified."

On 11/13/19 at approximately 3:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, regional director of clinical services, ASM #5, regional vice president, and LPN (licensed practical nurse) #1, unit manager were made aware of the findings.

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No further information was provided prior to exit.

Complaint Deficiency

References:

1. Diabetes:
A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

2. Dementia
A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690	F690

§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 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

1) Resident # 3 is receiving catheterizations as ordered.

2) 100% audit of current Residents with catheters to ensure appropriate treatment.

3) DNS/Designee will complete education for medication and treatment guidelines to include catheter care for nurses.

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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 resident interview, clinical record review, staff interview, facility document review and in the course of a complaint investigation, it was determined that the facility staff failed to provide appropriate treatment and services for a urinary catheter for one of eight residents in the survey sample, Resident #3. The facility staff failed to provide catheterization for Resident #3 as ordered twice daily on 10/16/19, 11/6/19 and 11/9/19 as ordered by the physician.

The findings include:

Resident #3 was admitted to the facility on 04/17/2018, with a readmission on 08/18/2019 with diagnoses that included but were not limited to urinary retention (1) and benign prostatic hyperplasia (2).

4) DNS/Designee will review audits of Medication administration records in clinical start up. Findings reported to QAPI committee monthly for further action if necessary.

5) Compliance Date: 12/3/2019

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Resident #3's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 08/29/19, coded Resident #3 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions.

On 11/12/19 at approximately 12:45 p.m., an interview was conducted with Resident #3. When asked about the catheterization procedures the staff provide to him, Resident #3 stated that a couple of months ago he had to complain to the staff because he was not getting the catheterization on the day shift. Resident #3 stated that it has gotten better since he complained; he stated that his sister met with the staff and they worked out a better schedule so it does not interfere with meals or activities and the nurses have time to do it. Resident #3 stated that he feels that there is a communication gap between staff at the facility and they need to work on it.

The facility provided document "Grievance Tracking Log:2019" documented for Resident #3, "Received 8/12/19, Resident and sister reported the following concerns missed and or late catheterizations, communication between staff and other resident behaviors in main dining room." It further documented, "Resolved 8/15/19, Resolution; Meeting held with IDT (interdisciplinary team) and concerns discussed. Residents cathettorzations [sic] to be done at 10a and 10p per resident request. Staff education to be done with staff on communication and explanation to resident and family on how to file a

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concern and where the forms are located. Observation to be done in dinning [sic] room." "Follow up, Satisfied with resolution; Resident and sister seemed satisfied with what was discussed in meeting and the follow up from facility."

The POS (physician order summary) dated "Nov (November) 12, 2019" documented, "Straight cath 10am and 10pm. Two times a day for urine retention. Order Date: 09/06/2019. Start Date: 09/06/2019."

The comprehensive care plan "Alteration in elimination of bowel and bladder history of UTI's (urinary tract infections), stress incontinence, constipation, in and out straight cath (catheterization) twice daily due to urinary retention. Date Initiated: 04/26/2018." Under "Interventions" it documented, "Catheterize as ordered. Date Initiated 08/10/2019. Revision on 09/28/2019."

The MAR (medication administration record) dated "10/1/2019-10/31/2019" documented, "Straight cath 10am and 10pm. Two times a day for urine retention, Order Date: 09/06/2019 1807 (6:07 p.m.)" The documentation box for the date 10/16/19 "1000 (10:00 a.m.)" documented the following "7 [Initials of LPN #2]." The MAR further documented under "Chart Codes/Follow up Codes" the following, "7=other/See Nurse Notes."

The progress note "10/16/19 09:28 (9:28 a.m.) eMAR (electronic medication administration note) Note Text: Straight cath 10am and 10pm. Two times a day for urine retention. No catheter insertion kits available."

The MAR dated "11/1/2019-11/30/2019"

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documented the order as above. The documentation boxes for the dates 11/6/19 "1000 (10:00 a.m.)" and 11/9/19 "1000 (10:00 a.m.)" were observed to be blank.

Review of the progress notes for Resident #3 for 11/6/19 and 11/9/19 failed to evidence documentation regarding catheterization for the scheduled 10am procedure.

On 11/13/19 at 1:30 p.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked about Resident #3's catheterization schedule, LPN #2 stated that it is scheduled for 10:00 am and 10:00 pm and that schedule is not working very well. LPN #2 stated that often-Resident #3 is in activities or the nurses are finishing morning medications and the catheterization has to be done later in the day. LPN #2 stated that the schedule was going to be discussed with the physician and Resident #3 to see what will be best. When asked how the catheters for Resident #3 are obtained, LPN #2 stated that the residents get them through their insurance company now and they are stocked in the room. LPN #2 stated that they just started this process and they used to run out of them before they started this process. LPN #2 stated that when the catheter kits were not available they would pull the supplies individually but at times did not have the sterile gloves needed for the procedure. When asked about the scheduled catheterization on 10/16/19 that documented as "no catheter insertion kits available", LPN #2 stated that he thinks that there were no sterile gloves available to perform the procedure. When asked what was done when he did not have the supplies that he needed, LPN #2 stated that he talked to Resident #3 and explained that it was a

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temporary issue and Resident #3 was fine with waiting. LPN #2 stated that he assessed Resident #3 for bladder distention and made sure he was urinating without problems. When asked if he notified anyone that the catheterization was not performed as ordered, LPN #2 stated that he did not. LPN #2 stated that he did have a phone list and could have contacted the registered nurse in the building or a unit manager by phone. LPN #2 stated, "If it's not there, it's not there." When asked what blank boxes on the MAR (medication administration record) mean LPN #2 stated that they mean the procedure was not signed off as completed. When asked if it can be determined if the catheterization was performed was performed by the MAR with the empty boxes, LPN #2 stated that it could not because there is no documentation. When asked if it should be documented on the MAR if it was refused or performed late, LPN #2 stated, "Yes, there are codes to put on there."

On 11/13/19 at 8:55 a.m., an interview was conducted with LPN #1, unit manager. When asked the process for keeping catheters on the units, LPN #1 stated that overnight delivery is available if needed and they can call a local supplier to get a shipment. When asked about Resident #3's catheters, LPN #1 stated that his catheters come from a different manufacturer now because his insurance covers the supplies and he should not run out of them. LPN #1 stated that sometimes Resident #3 is at breakfast or activities during the scheduled time for the catheterization and it is done later at his request or if an emergency comes up and it is late due to that. LPN #1 stated that the catheterization kits for Resident #3 are in his room and extra catheters are in the supply closets. LPN #1

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stated that central supply is at the facility during the day and someone is available on the weekends to get something as needed. LPN #1 reviewed the progress note dated 10/16/19 documenting "no catheter insertion kits available" and then stated that if no kits are available the supplies in the kits are separate and available for staff to get individually in the supply closet. When asked if there have been times when the catheterization was not done, LPN #1 stated that there have been a few times when he has not received the catheterization and the staff were educated. LPN #1 stated that the staff have met with the family and discussed the catheterization scheduled and all staff has been educated on it. When asked why Resident #3 has the order to perform straight catheterization twice a day, LPN #1 stated that he has BPH (benign prostatic hyperplasia) with urinary retention.

On 11/13/19 at 4:30 p.m., ASM (administrative staff member) #3, the regional director of clinical services stated that the facility uses their policies and Lippincott as their standard of practice.

According to Lippincott Nursing Procedures, Seventh Edition, Intermittent Urinary Catheterization, page 409, "Intermittent urinary catheterization is used long-term or short-term, depending on the patient's condition. When used routinely, it should be performed at regular intervals throughout the day according to the patient's fluid intake to prevent bladder over distention."

On 11/13/19 at approximately 3:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4,

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F 690	Continued From page 49 regional director of clinical services, ASM #5, regional vice president, and LPN (licensed practical nurse) #1, unit manager were made aware of the findings. No further information was presented prior to exit. Complaint Deficiency References: 1. Urinary retention- Urinary retention is the inability to empty the bladder completely. Urinary retention can be acute or chronic. Acute urinary retention happens suddenly and lasts only a short time. People with acute urinary retention cannot urinate at all, even though they have a full bladder. Acute urinary retention, a potentially life-threatening medical condition, requires immediate emergency treatment. Acute urinary retention can cause great discomfort or pain. This information was obtained from the website: https://www.niddk.nih.gov/health-information/urologic-diseases/urinary-retention#sec1 2. Benign prostatic hyperplasia An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.	F 690		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755	F755 1) Resident # 7 is receiving medications per Physician orders.	

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§483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation it was determined that the facility staff failed to provide pharmacy services for one of eight residents in the survey sample, Resident #7. Resident #7's antibiotic was not available for administration as prescribed after a readmission to the facility on 11/11/19.

The findings include:

2) Re-admissions with antibiotic orders have the potential to be affected.

3) DNS/Designee will complete education for medication availability guidelines for nurses.

4) DNS/Designee will review re-admissions in start-up. Findings reported to QAPI committee monthly for further action if necessary.

5) Compliance Date: 12/3/2019

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Resident #7 was admitted to the facility on 11/12/2014 with a readmission on 11/11/2019. Resident #7's diagnoses included but were not limited to cellulitis (1) and dementia (2). Resident #7's most recent MDS (minimum data set), a thirty day assessment with an ARD (assessment reference date) of 09/25/19, coded Resident #7 as scoring a 6 (six) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 6- being severely impaired for making daily decisions.

The comprehensive care plan for Resident #7 "Abx (antibiotic) therapy ZYVOX 600 mg (milligram) x5 (for five) days for cellulitis, Date Initiated: 11/12/2019." documented "[Name of Resident #7] will complete Abx therapy as order, Date Initiated: 11/12/2019."

The document "Discharge Summary" from [Name out Hospital group] dated "11/11/2019 2:17 PM" documented in part, "linezolid (generic name of antibiotic) 600 mg tablet commonly known as: Zyvox, Take 1 (one) tablet (600 mg total) by mouth 2 (two) times daily for 7 (seven) days."

Review of the POS (physician order summary) for Resident #7 on 11/11/2019 at 1:45 p.m. revealed the medication documented above with the following "Order Date 1/11/2019; Start Date 11/11/2019; End Date 11/18/2019."

Review of the MAR (Medication Administration Record) for Resident #7 for "11/1/2019-11/30/2019" documented the physicians order as listed above. In the area on the MAR for 11/12/19 "0900 (9:00 a.m.)" it documented "3 [Initials of RN (registered nurse)

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#1]." In the area on the MAR "Chart Codes/Follow up Codes" it documented "3=Hold/See Nurse Notes."

Review of the nurses "Progress Notes" dated "11/12/19 0811 (8:11 a.m.) eMAR (electronic medication administration record) Medication Administration Note, Linezolid Tablet 600 MG Give 1 tablet by mouth two times a day for cellulitis for 7 days. Note Text: Awaiting delivery."

On 11/12/19 at approximately 2:30 p.m., an interview was conducted with RN (registered nurse) #1. When asked about the Linezolid 600mg ordered for Resident #7, RN #1 stated, "We have not received it from the pharmacy and are not sure when the order will come in." When asked about the process for ordering medications from the pharmacy for newly admitted residents, RN #1 stated "The order gets faxed to the pharmacy, the pharmacy gets the order and it is delivered the next day in the evening around 10:00 p.m." When asked when the order for the medication was received for Resident #7, RN #1 stated that the order was received when the resident returned from the hospital on 11/11/19 in the afternoon. When asked about the process staff follows when a scheduled medication is not available for a resident, RN #1 stated that staff look for a backup medication from the facility stock or call the pharmacy to send it stat (immediately). RN #1 stated that she had not had time to talk to the pharmacy today about Resident #7's Linezolid 600mg that it would be in tonight around 10:00 p.m. with the delivery but she could go back and call. When asked about the documentation on the eMAR (electronic medication administration) of "3", RN #1 stated that meant to see the nurse's notes where she

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wrote that the medication had not arrived from the pharmacy. When asked why the Linezolid was prescribed for Resident #7, RN #1 stated that he was taking it for cellulitis after an admission to the hospital. RN #1 stated she was going to go and call the pharmacy to see if she could get the medication in before 10:00 p.m. so that Resident #7 would not miss any more doses of his antibiotic.

On 11/12/19 at 3:50 p.m., RN #1 stated that she had spoken with the pharmacy regarding the order for the Linezolid for Resident #7 and that they are sending the medication to the facility as a stat (immediate) medication.

On 11/13/19 at 11:20 a.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked about the process for transcribing orders for new admissions, LPN #3 stated that the discharge orders are used from the receiving facility. LPN #3 stated that the staff let the provider know that the resident has arrived and review the discharge orders and any medications that the resident brought with them with the provider to verify them. LPN #3 stated that they then put the orders into the computer system. When asked about the process for getting orders to the pharmacy, LPN #3 stated that the orders are faxed and that she follows up the fax with a phone call to ensure that it was received. LPN #3 stated that they give what medications they can from the stock medications and the others are normally here the next day. LPN #3 stated that if medications are needed right away there is a protocol in place but she was not sure exactly of the period for it. When asked what it done if an ordered medication does not come in as expected, LPN #3 stated that staff should call the

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provider to see if it should be substituted with something else or if it is all right to hold it or not give it. LPN #3 stated that if it is something that is needed right away there have a backup pharmacy to use.

On 11/13/19 at 1:30 p.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked the process for getting medication orders to the pharmacy for residents, LPN #2 stated that after medication orders are sent to the pharmacy they get medication deliveries three times a day Monday through Friday with the latest being around 1:00 a.m. or 2:00 a.m. LPN #2 stated that on the weekends pharmacy delivers twice a day. LPN #2 stated that the facility also has stat boxes, which hold frequently used medications and emergency medications.

On 11/13/19 at 9:20 a.m., an interview was conducted with ASM (administrative staff member) #6, nurse practitioner. When asked if a medication is not available or not received from pharmacy as expected would she expected to be notified, ASM #6 stated that she would expect to be notified by the end of the shift. When asked about the scheduled dosage of Linezolid 600mg for Resident #7 on 11/12/19 at 9:00 a.m. ASM #6 stated that she was made aware that the medication was not available when speaking with RN #1 around 12 noon on 11/12/19. ASM #6 stated that she and the director of nursing met this morning and they are working to come up with a plan for getting newly admitted residents medications promptly. When asked if the Linezolid would be important in Resident #7's plan of care after the recent hospitalization for cellulitis, ASM #6 stated that she would want him to have the antibiotic in a timely manner and that

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is why they have to work together to come up with a plan. ASM #6 stated that Resident #7's cellulitis is pretty much resolved and the delay in getting his medication has not affected his plan of care.

On 11/13/19 at approximately 1:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy for placing medication orders to pharmacy.

On 11/13/19 at 4:30 p.m., ASM (administrative staff member) #3, the regional director of clinical services stated that the facility uses their policies and Lippincott as their standard of practice.

The facility policy "Medication Administration General Guidelines, 09/18" documented in part "If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (for example, the resident is not in the nursing care center at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN (as needed) documentation. If two consecutive doses of a vital medication are withheld or refused, the physician is notified."

According to Lippincott Manual of Nursing Practice, 10th Edition, Dermatologic Disorders, Cellulitis, page 1157-1158, "Cellulitis is a diffuse inflammation of the deep dermal and subcutaneous (under the skin) tissue that results from an infectious process...Patient Education and Health Maintenance, 1. Make sure that patient understands dosage schedule of

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antibiotics and the importance of complying with therapy to prevent complications."

On 11/13/19 at approximately 3:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, regional director of clinical services, ASM #5, regional vice president, and LPN (licensed practical nurse) #1, unit manager were made aware of the findings.

No further information was provided prior to exit.

References:

1. Cellulitis
A common skin infection caused by bacteria. It affects the middle layer of the skin (dermis) and the tissues below. Sometimes, muscle can be affected.. This information was obtained from the website:
https://medlineplus.gov/ency/article/000855.htm.

2. Dementia
A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website:
https://medlineplus.gov/ency/article/000739.htm.

F 880 SS=D — Infection Prevention & Control
CFR(s): 483.80(a)(1)(2)(4)(e)(f)

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the

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1) Resident #8's is receiving medication in a sanitary manner.

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development and transmission of communicable diseases and infections.

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

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

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

2) Current residents have the potential to be affected.

3) DNS/Designee will complete education on infection control during medication

administration with licensed nurses.

4) DNS/Designee will conduct Medication observations to include infection control for 3 licensed nurses per week for 8 weeks. Findings reported to QAPI committee monthly for further action if necessary.

5) Compliance Date: 12/3/2019

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(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 and clinical record review, it was determined that the facility staff failed to implement infection control practices for one of eight residents in the survey sample, Resident #8. The facility staff failed to administer medications to Resident #8 in a sanitary manner on 11/12/19. LPN [licensed practical nurse] #4 was observed touching the drawers of the medication cart with her bare hands. LPN #4 was then was observed popping pills from medications packs and dropping pills form medication bottles into her bare hands before placing the pills into the pill cup and was observed dropping a pill into the drawer of the medication cart, picking the pill up with her bare hand and placing the pill back into the medication bottle.

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The findings include:

Resident #8 was admitted to the facility on 7/15/19. Resident #8's diagnoses included but were not limited to stroke, diabetes and high blood pressure. Resident #8's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/18/19, coded the resident's cognitive skills for daily decision making as modified independence (some difficulty in new situations only).

On 11/12/19 at 11:03 a.m., LPN (licensed practical nurse) #4 was observed preparing Resident #8's medications. While preparing the medications, LPN #4 was observed touching the drawers of the medication cart with her bare hands then popping pills from medications packs and dropping pills form medication bottles into her bare hands before placing the pills into the pill cup. In addition, LPN #4 dropped a probiotic pill into the drawer of the medication cart, picked the pill up with her bare hand and placed the pill back into the medication bottle. After preparing the medications, LPN #4 walked into Resident #8's room. After entering the room, LPN #4 was observed touching the remote control for the bed and the floor with her bare hands while attempting the raise the resident's bed. After raising the bed, LPN #4 administered the medications to Resident #8. While taking the medications, Resident #8 dropped two pills on her bed. LPN #4 picked up the pills with her bare hands and administered them to the resident.

On 11/12/19 at 4:25 p.m., an interview was conducted with LPN #4. LPN #4 was asked if nurses should touch medications with their bare

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hands. LPN #4 stated, "I don't see why not unless there is an order not to." LPN #4 stated she pops and places medications into her bare hands to keep the medications from "shooting all over the place." LPN #4 was asked if medications could be contaminated if a nurse touches the medication cart handles then touches the medications. LPN #4 stated, "Yeah, when you put it that way, I'd say yes." When asked if a pill could be contaminated after being dropped in a medication cart drawer, LPN #4 stated it could be.

On 11/13/19 at 9:14 a.m., an interview was conducted with LPN #1 (unit manager). LPN #1 was asked if a nurse should touch a resident's pills with her bare hands. LPN #1 stated, "No." When asked why, LPN #1 stated, "Well it's contamination to start with. Even if dropped on a resident, you want to get rid of it. Get a new pill. You don't know what's on their clothes, hands or sheets." LPN #1 further confirmed that a pill dropped in the drawer of a medication cart should be discarded.

On 11/13/19 at 2:45 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), LPN #1, ASM #3 (regional director of clinical services), ASM #4 (another regional director of clinical services) and ASM #5 (regional vice president) were made aware of the above concern.

The facility/pharmacy policy regarding medication administration documented information regarding hand washing and hand sanitizer but failed to document specific information regarding the above concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 880	Continued From page 61 No further information was presented prior to exit.	F 880		