STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495173	A. BUILDING _____ B. WING _____	C 12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERSIDE HEALTH & REHAB CENTER	249 SOUTH NEWTOWN RD NORFOLK, VA 23502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 12/10/19 through 12/12/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/10/19 through 12/12/19. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long term Care requirements. The Life Safety Code survey/report will follow. Five complaints were investigated during the survey. The census in this 197 certified bed facility was 95 at the time of survey. The survey consisted of 34 current Resident reviews and 9 closed record reviews.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §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)(l) 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	F 583	1. It was identified that while performing tracheostomy care for resident #2 the respiratory therapist did not provide privacy for the resident. The respiratory therapist involved was immediately educated regarding privacy while providing care for residents. 2. Residents in the facility who require care from facility staff have potential for privacy issues. 3. Staff will be educated by the SDC on dignity and providing privacy during care. 4. The DON or designee will audit 25% of residents weekly for privacy during care for 4 weeks and 10% weekly for 4 weeks. An ADHOC QAPI was held 12/18/19 to discuss. Audit results will be reviewed at QAPI monthly for 3 months. 5. Date of compliance: January 7, 2020	1/7/2020

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

Chris Acorn — Administrator — January 7, 2020

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

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F 583	Continued From page 1 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 and staff interviews the facility staff failed to protect resident from public view during care for 1 resident (Resident #2), of 43 residents in the survey sample. The facility staff failed to ensure Resident #2's privacy was maintained during tracheostomy care. The findings included: Resident #2 was originally admitted to the facility on 03/28/19. Diagnosis for Resident #2 included but are not limited to *Tracheostomy, Ventilator and Persistent Vegetative State. Resident #2's Minimum Data Set (MDS-an assessment protocol), a quarterly assessment with an Assessment Reference Date of 09/09/19,	F 583		

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F 583	Continued From page 2	F 583		

coded Resident #2 requiring total dependence of two with dressing, bed mobility, bathing, and toilet use, total dependence of one with hygiene and eating.

On 12/12/19 at approximately 8:30 a.m., the Respiratory Therapist (RT) performed tracheostomy care with two surveyors present. While tracheostomy care was being provided on Resident #2's, the privacy curtain was not pulled nor was her door closed to provide privacy. The RT performed tracheostomy care as follows:
-Removed gauze from around trach, removed inner trach cannula, inner cannula trach replaced, gloves removed then washed her hands.
-RT left the room, remove a split gauze from the treatment cart, came back into the room; door remained open and curtain still not pulled for privacy.
-Washed hands, donned a new pair of gloves, cleaned around trach site with wet saline gauze.
-Placed a new split gauze around Resident #2's trach.
-Suctioned Resident #2, gloves removed, hands washed.
-Applied new gloves: listen to breathe sounds, then position Resident #2's head for comfort.

During the tracheostomy care procedure, the resident could be viewed by anyone walking past the doorway because the privacy curtain was not pulled and the door was left opened.

On 12/12/19, immediately following tracheostomy care, the RT was asked, "Should the door be closed or the curtain pulled while providing trach care on Resident #2" she replied, "Yes, I should have closed the door or pulled the curtain." The RT was asked, "What is the purpose for pulling

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the curtain or closing the door while providing tracheostomy care on (Resident #2)," she replied, "Normally, we do pull the curtain for privacy."

An interview was conducted with Director of Nursing (DON) and Regional Director Vice President of Operations on 12/12/19 at approximately 2:01 p.m. The DON said the therapist should have pulled the curtain and close the door as necessary to provide dignity and privacy of the resident.

A briefing was held with the Administrator, Director of Nursing and Regional Director of Clinical Services on 12/12/19 at approximately 6:53 p.m. The facility did not present any further information about the findings.

The facility's policy titled Resident's Privacy (Revised 04/2015).
-Purpose: All personnel will provide resident privacy to the maximum extent possible, in order to maintain the privacy of their bodies.

-Procedure include but not limited to:
-Residents shall be examined and treated in a manner that maintains the privacy of their bodies.
-A closed door, drawn curtain, or both, shield the resident from passersby, as well as their roommate.
-Resident's should be draped and dressed appropriately at all times to avoid exposure of embarrassment.
-Privacy is also maintained during toileting, bathing, and other activities of personal hygiene.
-Protecting the resident's privacy is a very important aspect of resident care and a right guaranteed by the Resident's Bill of Rights.

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F 583	Continued From page 4 Definitions: -Tracheostomy is a hole that surgeons make through the front of the neck and into the windpipe (trachea). A tracheostomy tube is placed into the hole to keep it open for breathing (Mayoclinic.com). -Ventilator is a machine that supports breathing. Ventilators: Get oxygen into the lungs, remove carbon dioxide from the body (Carbon dioxide is a waste gas that can be toxic), help people breathe easier and breathe for people who have lost all ability to breathe on their own (nih.gov). -Persistent Vegetative State is a person with overwhelming damage to the cerebral hemispheres commonly pass into a chronic state of unconsciousness (ie, loss of self-awareness) called the vegetative state. When such cognitive loss lasts for more than a few weeks, the condition has been termed a persistent vegetative state, because the body retains the functions necessary to sustain vegetative functions (nih.gov).	F 583		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at	F 607	1. It was identified that the facility was unable to provide documentation of a 5 day follow up to a FRI that had been submitted. Resident #84 was discharged prior to the survey. 2. Residents who require a FRI are at risk. 3. Administrator and DON have been educated on the policy regarding notification to state and federal agencies and obtaining confirmation of notification submission. 4. The administrator and/or designee will perform 100% audit of all reportable investigations for the past 8 weeks submitted to OLC to ensure there is proof of confirmation of successful fax delivery. Findings will be reviewed monthly in QAPI for recommendations. An ADHOC for initial plan was held 12/18/19. 5. Date of compliance: January 7, 2020	1/7/2020

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F 607	Continued From page 5 paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to implement their abuse policies by failing to submit to the appropriate state agencies, a five day follow up investigation to a FRI (facility reported incident) that was reported on 1/7/19, for one of 43 residents in the survey sample, Resident #84. The findings included: Resident #84 was admitted to the facility on 5/12/15 with diagnoses that included but were not limited to hemiplegia (one sided paralysis) and aphasia (loss of ability to express speech) status post stroke, and type two diabetes. Resident #84 passed away on 10/15/19, therefore a closed record review was conducted. Resident #84's most recent comprehensive MDS (minimum data set) assessment was an significant change assessment with an ARD (assessment reference date) of 10/15/19. Resident #84 was coded as being severely impaired in cognitive function scoring 99 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #84 was coded as being totally dependent on staff with ADLS (activities of daily living). Review of the facility FRIs (facility reported incidents) revealed a FRI that was submitted to the State Survey Agency on 1/7/19 regarding Resident #84. The following FRI was documented in part, "Standard Notes: Allegations of neglect in care of resident. Investigation Pending." An APS	F 607		

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(Adult Protective Service) report was attached to the FRI. The following was documented: "Caller reports for client who resides at (Name of Nursing Facility) and has for the last 6 years. Caller states client has a history of stroke, diabetes, is currently a feeding tube and has difficulty communicating. Caller is concerned the facility is not giving the client the appropriate level of care and may be neglecting client. Caller states that she herself recently had back surgery and was unable to visit with the client for quite some time, until recently when she visited after the holidays. Caller states that when she saw the client in her room, that client's face appeared very swollen, to which she assumes is from an abscess on her tooth from almost a year ago that she has repeatedly asked the facility to address. Caller states that when she went to speak with someone from the front desk about the client's care, that she was informed no information would be provided to her as she was now banned from the facility. Caller states she is unsure how or why this has happened as she is the one who had been taking client to all her necessary medical appointments in the past and visited with her at that day. Caller states she has left several messages for the staff at the facility but that no one will get back to her or return her calls..."

Review of Resident #84's clinical record revealed that Resident #84 had complaints of mouth pain on 10/3/19. The following nursing note was documented in part, "Resident stated she was in pain and pointed to her mouth."

Review of Resident #84's October 2018 nursing notes revealed she had an abscess to her tooth on 10/4/19. The following note was documented: 'Resident started on ABT (antibiotic) clindamycin

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F 607	Continued From page 7 (antibiotic)(1) for abscesses (sic)." Review of Resident #84's October 2018 MAR (medication administration record) revealed that the Resident was started on Clindamycin on 10/4/19 and had ended on 10/10/19. There was no evidence that Resident #84 had any further concerns related to a tooth abscess once antibiotics were completed on 10/10/19. A nursing note dated 11/13/18, documented an incident between Resident #84's daughter (complainant) and the facility. The note documented the following: "pt daughter (Name of patient's daughter) was notified that this nurse was not able to give her pt information because she was not on the face sheet as the POA (power of attorney). I notified her it was (Name of social service agency). The daughter began to threaten staff so I called 911. The daughter told (Name of social service agency) and the police that the pt (patient) had feces going up back and her face was swollen. I notified (Name of case manager), the feces and swollen face was not true. I notified (Name of case manager) that she became angry when we did not give her information from the patient's chart...The police arrived and I escorted them to the pt (patient's) room to show them that the patient face was not swollen and she was not in feces. The police agreed that she look fine. We then notified the police that (Name of daughter) will not be allowed back on property until she speaks with management on Monday. The officers (stated) they will her know that she is not allowed back on the property at this time and she will have to leave until she speaks with management."	F 607		

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F 607	Continued From page 8 Further review of Resident #84's clinical notes revealed an incident with Resident #84's daughter (another daughter) being disruptive on 12/25/18. The following note was documented: "Pts (patients) daughter, (Name of Patient's Daughter) was escorted to N4 (unit 4) nursing station to speak with me about her concerns with her mothers care, or lack thereof. She wanted a "state complaint form" to fill out. When I turned my back to find one she turned to her companion and said, "I hate this b****, I've had to deal with her before." A call was made to DON (Director of Nursing), (name of DON), and a message was left to please call back with information on where to find forms. Called and spoke with (Name of Unit Manager) who informed this RN (Registered Nurse) that there was a "No trespassing" letter addressed to (Name of daughter). I signed the letter and showed it to the daughter. Told her that she would need to leave now. She left relatively quiet after telling pt, "I Will be back to see you tomorrow. She left the building along with her two daughters. She has asked if they had to leave also. I told her the letter only stated that SHE could be here. Two hours later, I was asked to come to N3 (nursing station) 3 again to a belligerent family member. Upon arrival to pts room, pts granddaughter, (Name of granddaughter) was seated outside the room. I went into the room and spoke first with the LPNs (Licensed Practical Nurses) and CNas (Certified Nursing Assistants) caring for the patient. It was said that the daughter said derogatory remarks in their presence and called them "bitches." I informed her that it was not ok for her to insult or threaten my staff and that as much as I sympathized with her concerns, she would need to leave the building. She stated she would leave as soon as she said goodbye to the patient.	F 607		

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Finally, after saying goodbyes spending more than 5 minutes saying her goodbyes and loudly assuring the pt she would be back to visit her tomorrow, the young lady left the building...only two people have been approved by (social service agency) to visit pt, (Name of two family members)... All other visitors can be turned away and told to contact (social service agency) "

Further review of the FRIs revealed no evidence that a five-day follow up to the investigation was submitted to the appropriate state agencies for the above allegation of neglect.

On 12/10/19 at approximately 12:00 p.m., ASM (administrative staff member) #3, the Regional Director of Clinical Services stated that the facility had changed companies in July of 2019 and any resident records, FRI'S, and grievances prior to July of 2019, would be hard to obtain. ASM #3 would have to ask the old company to send over documents. ASM #3 was asked to provide the follow up to the FRI submitted on 1/7/19 for Resident #84.

On 12/12/19 at 9:52 a.m., ASM #3 stated that she was not able to provide evidence that the follow up investigation was sent to the appropriate state agencies. ASM #3 stated that she was the DON (Director of Nursing) with the old company at the time of the above incident. ASM #3 stated that she knew an investigation was conducted but could not speak to the follow-up FRI. When asked the process for reporting an allegation of abuse, ASM #3 stated that an allegation of abuse should be reported immediately, usually within 2 hours if abuse is founded to the appropriate state agencies such as police, APS (Adult Protective Services), and (Name of State Survey Agency)

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F 607	Continued From page 10 etc. ASM #3 stated that an investigation would be initiated and the results would be sent to the same state agencies within five working days. ASM #3 was made aware of the above concerns. On 12/12/19 at the pre-exit meeting (6:55 p.m.) ASM (administrative staff member) #1, the Administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. No further information was presented prior to exit. The facility's abuse policy documented in part, the following "...Final Report will be submitted to the applicable State agency, after the investigation is completed, but no later than (5) working days from the alleged occurrence." (1) This information was obtained from the National Institutes of Health. https://www.ncbi.nlm.nih.gov/books/NBK519574/	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 609	1. It was identified that the facility was unable to provide documentation of a 5 day follow up to a FRI that had been submitted. Resident #84 was discharged prior to the survey. 2. Residents who require a FRI is at risk. 3. Administrator and DON have been educated on the policy regarding timely notification to state and federal agencies. 4. The administrator and/or designee will perform 100% audit of all reportable investigations for the past 8 weeks submitted to OLC to ensure there is proof of confirmation of successful fax delivery. Findings will be reviewed monthly in QAPI for recommendations. An ADHOC for initial plan was held 12/18/19. 5. Date of compliance: January 7, 2020	1/7/2020

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F 609	Continued From page 11 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that facility staff failed to submit the results of an investigation within 5 working days of an allegation of neglect reported on 1/7/19 to the appropriate state agencies for one of 43 residents in the survey sample, Resident #84. The findings included: Resident #84 was admitted to the facility on 5/12/15 with diagnoses that included but were not limited to hemiplegia (one sided paralysis) and aphasia (loss of ability to express speech) status post stroke, and type two diabetes. Resident #84 passed away on 10/15/19 therefore, a closed record review was conducted. Resident #84's most recent comprehensive MDS (minimum data set) assessment was an significant change assessment with an ARD	F 609		

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(assessment reference date) of 10/15/19. Resident #84 was coded as being severely impaired in cognitive function scoring 99 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #84 was coded as being totally dependent on staff with ADLS (activities of daily living).

Review of the facility FRIs (facility reported incidents) revealed a FRI that was submitted to the State Survey Agency on 1/7/19 regarding Resident #84. The following FRI documented in part, "Standard Notes: Allegations of neglect in care of resident. Investigation Pending." An APS (Adult Protective Service) report was attached to the FRI. The following was documented: "Caller reports for client who resides at (Name of Nursing Facility) and has for the last 6 years. Caller states client has a history of stroke, diabetes, is currently a feeding tube and has difficulty communicating. Caller is concerned the facility is not giving the client the appropriate level of care and may be neglecting client. Caller states that she herself recently had back surgery and was unable to visit with the client for quite some time, until recently when she visited after the holidays. Caller states that when she saw the client in her room, that client's face appeared very swollen, to which she assumes is from an abscess on her tooth from almost a year ago that she has repeatedly asked the facility to address. Caller states that when she went to speak with someone from the front desk about the client's care, that she was informed no information would be provided to her as she was now banned from the facility. Caller states she is unsure how or why this has happened as she is the one who had been taking client to all her necessary medical appointments in the past and visited with her at

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that day. Caller states she has left several messages for the staff at the facility but that no one will get back to her or return her calls..."

Review of Resident #84's clinical record revealed that Resident #84 had complaints of mouth pain on 10/3/19. The following nursing note was documented in part, "Resident stated she was in pain and pointed to her mouth."

Review of Resident #84's October 2018 nursing notes revealed she had an abscess to her tooth on 10/4/19. The following note was documented: "Resident started on ABT (antibiotic) clindamycin (antibiotic)(1) for abscesses (sic)."

Review of Resident #84's October 2018 MAR (medication administration record) revealed that the Resident was started on Clindamycin on 10/4/19 and had ended on 10/10/19.

There was no evidence that Resident #84 had any further concerns related to a tooth abscess once antibiotics were completed on 10/10/19.

A nursing note dated 11/13/18, documented an incident between Resident #84's daughter (complainant) and the facility. The note documented the following: "pt daughter (Name of patient's daughter) was notified that this nurse was not able to give her pt information because she was not on the face sheet as the POA (power of attorney). I notified her it was (Name of social service agency). The daughter began to threaten staff so I called 911. The daughter told (Name of social service agency) and the police that the pt (patient) had feces going up back and her face was swollen. I notified (Name of case manager), the feces and swollen face was not true. I notified

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(Name of case manager) that she became angry when we did not give her information from the patient's chart...The police arrived and I escorted them to the pt (patient's) room to show them that the patient face was not swollen and she was not in feces. The police agreed that she look fine. We then notified the police that (Name of daughter) will not be allowed back on property until she speaks with management on Monday. The officers (stated) they will her know that she is not allowed back on the property at this time and she will have to leave until she speaks with management."

Further review of Resident #84's clinical notes revealed an incident with Resident #84's daughter (another daughter) being disruptive on 12/25/18. The following note was documented: "Pts (patients) daughter, (Name of Patient's Daughter) was escorted to N4 (unit 4) nursing station to speak with me about her concerns with her mothers care, or lack thereof. She wanted a "state complaint form" to fill out. When I turned my back to find one she turned to her companion and said, "I hate this b****, I've had to deal with her before." A call was made to DON (Director of Nursing), (name of DON), and a message was left to please call back with information on where to find forms. Called and spoke with (Name of Unit Manager) who informed this RN (Registered Nurse) that there was a "No trespassing" letter addressed to (Name of daughter). I signed the letter and showed it to the daughter. Told her that she would need to leave now. She left relatively quiet after telling pt, "I Will be back to see you tomorrow. She left the building along with her two daughters. She has asked if they had to leave also. I told her the letter only stated that SHE could be here. Two hours later, I was asked to

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F 609	Continued From page 15 come to N3 (nursing station) 3 again to a belligerent family member. Upon arrival to pts room, pts granddaughter, (Name of granddaughter) was seated outside the room. I went into the room and spoke first with the LPNs (Licensed Practical Nurses) and CNas (Certified Nursing Assistants) caring for the patient. It was said that the daughter said derogatory remarks in their presence and called them "bitches." I informed her that it was not ok for her to insult or threaten my staff and that as much as I sympathized with her concerns, she would need to leave the building. She stated she would leave as soon as she said goodbye to the patient. Finally, after saying goodbyes spending more than 5 minutes saying her goodbyes and loudly assuring the pt she would be back to visit her tomorrow, the young lady left the building...only two people have been approved by (social service agency) to visit pt. (Name of two family members)... All other visitors can be turned away and told to contact (social service agency)." Further review of the FRIs revealed no evidence that a five-day follow up to the investigation was submitted to the appropriate state agencies for the above allegation of neglect. On 12/10/19 at approximately 12:00 p.m., ASM (administrative staff member) #3, the Regional Director of Clinical Services stated that the facility had changed companies in July of 2019 and any resident records, FRI'S, and grievances prior to July of 2019, would be hard obtain. ASM #3 would have to ask the old company to send over documents. ASM #3 was asked to provide the follow up to the FRI submitted on 1/7/19 for Resident #84.	F 609		

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F 609	Continued From page 16 On 12/12/19 at 9:52 a.m., ASM #3 stated that she was not able to provide evidence that the follow up investigation was sent to the appropriate state agencies. ASM #3 stated that she was the DON (Director of Nursing) with the old company at the time of the above incident. ASM #3 stated that she knew an investigation was conducted but could not speak to the follow-up FRI. When asked the process for reporting an allegation of abuse, ASM #3 stated that an allegation of abuse should be reported immediately, usually within 2 hours if abuse is founded to the appropriate state agencies such as police, APS (Adult Protective Services), and (Name of State Survey Agency) etc. ASM #3 stated that an investigation would be initiated and the results would be sent to the same state agencies within five working days. ASM #3 was made aware of the above concerns. On 12/12/19 at the pre-exit meeting (6:55 p.m.) ASM (administrative staff member) #1, the Administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. No further information was presented prior to exit. The facility's abuse policy documented in part, the following "...Final Report will be submitted to the applicable State agency, after the investigation is completed, but no later than (5) working days from the alleged occurrence." (1) This information was obtained from the National Institutes of Health. https://www.ncbi.nlm.nih.gov/books/NBK519574/	F 609		
F 622	Transfer and Discharge Requirements	F 622		

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F 622 SS=D	Continued From page 17 CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to	F 622	1. Facility failed to send copy of bed hold agreement and care plan goals with residents #61, #63 & #71 at the time of transfer. Identified residents have returned to facility. 2. Residents with the potential to be transferred to the hospital have the potential to be affected by this. A 100% facility audit of all residents transferred to the hospital in the past 30 days will be done to ensure that the bed hold agreement and care plan goals were sent with the resident. 3. Nursing staff will be educated by the SDC and/or designee on the correct documentation required when transferring a resident with an emphasis on the bed hold agreement and the care plan goals. They will also be educated on the proper documentation to verify that the information was sent on transfer. 4. The DON and/or designee will conduct an audit of all residents transferred to the hospital to ensure that all required documentation was sent with transfer. This audit will be completed 5 times a week for 3 month. An ADHOC QAPI was held on 12/18/19 to discuss this deficient practice and the plan of correction to improve it. Audit results will be reviewed monthly at QAPI for 3 months. 5. Date of Compliance January 7, 2020	1/7/2020

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F 622	Continued From page 18 discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include. (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information	F 622		

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F 622	Continued From page 19 (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to send the required documentation to include care plan goals upon transfer to the hospital, for 3 of 43 residents in the survey sample, Residents # 61, #71, #63. The findings included: 1. Resident #61 was admitted to the facility on 4/16/19 and readmitted on 11/30/19 with diagnoses that included but were not limited to spinal cord compression, dependence on ventilator, trachesostomy and gastronomy status (feeding tube). Resident #61's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 9/17/19. Resident #61 was coded as being severely impaired in cognitive function scoring 09 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #61 was coded as being dependent on staff for all ADLS (activities of daily living). Review of Resident #61's clinical record revealed that she had been transferred to the hospital on 11/23/19. The following nursing note was	F 622		

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F 622	Continued From page 20 documented in part: "Resident noted to be jerking and throwing arms about, sweating and noted a pasty bowel movement, amber urine and skin to touch. Noted secretions from mouth. Noted some red tinge coming from trach..." Review of Resident #61's SNF/NF (skilled nursing facility/nursing facility) transfer form failed to evidence that care plan goals were sent with Resident #61 at the time of hospital transfer. On 12/11/19 at 5:08 p.m., an interview was conducted with Registered Nurse (RN) #2. When asked what documents were sent with Residents upon transfer to the hospital, RN #2 stated that nurses were supposed to send the face sheet, medication list, transfer summary, advanced directives, and the bed hold policy. RN #2 stated that nurses should be documenting in a nursing note what documents were sent with the resident at the time of transfer. RN #2 stated that nursing staff should also be checking off the "Acute Care Transfer" list. RN #2 showed this writer that the "Acute Care Transfer List" was a check off list of documents sent with the resident to the hospital. Care plan goals was not an option on this list. RN #2 stated that nurses usually write in "CP goals" on the sheet. RN #2 stated however the checklist was mostly adhered to during the day shifts. Facility staff could not present an "Acute Care Transfer List" for Resident #61. On 12/12/19 at the pre-exit meeting (6:55 p.m.) ASM (administrative staff member #1, the Administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the Regional Director of Clinical Services were made aware of the above concerns. No further information was presented	F 622		

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F 622	Continued From page 21 prior to exit. 2. The facility staff failed to ensure that Resident #71's Plan of Care Summary to include his care plan goals was sent upon transfer/discharge to the hospital on 08/15/19. Resident #71 was originally admitted to the facility on 12/19/14 and re-admitted on 08/19/19. Diagnoses for Resident #71 included but not limited to, Essential Hypertension and Major Depressive Disorder. The current Minimum Data Set (MDS), an annual assessment with an Assessment Reference Date (ARD) of 06/13/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The Discharge MDS assessment was dated for 08/15/19 and included: discharged with return anticipated. On 08/15/19, according to the facility's documentation, Resident #71 was sent to the local Emergency Room (ER). Resident picked up at 6:05 PM and daughter notified right after. There was no documentation indicating the care plan goals were sent with the resident upon transfer to the hospital. A pre-exit meeting was held with the administrator, Director of Nursing and Corporate Nurse Consultant on 12/12/19 at approximately 3:05 p.m. No further comments were made. 3. Resident #63 was originally admitted to the facility on 05/27/2017. Resident #63 was discharged to the hospital on 10/08/2019 and	F 622		

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F 622	Continued From page 22 readmitted to the facility on 10/10/2019. Diagnoses included but not limited to Nontraumatic Subarachnoid Hemorrhage, Unspecified and Persistent Vegetative State. Resident #63's Annual Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 11/18/2019 coded Resident #63 as severely impaired cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #63 as requiring total assistance of 1 with dressing and bathing and total dependence of 2 with bed mobility, eating, toilet use and personal hygiene. On 12/11/2019 the Regional Director of Clinical Services was asked for evidence that Resident #63's care plan goals were sent with the resident upon discharge to the hospital on 10/08/2019. On 12/11/2019 at approximately 3:55 p.m., an interview was conducted with the Regional Director of Clinical Services and she stated, "I am unable to provide any evidence that the care plan goals were sent to the hospital when (Resident Name) was discharged on 10/08/2019." On 12/12/2019 at 1:30 p.m., during a briefing an interview was conducted with the Director of Nursing and when she was asked what her expectations are of the nurses when residents are sent to the hospital she stated, "I expect the nurses to send the resident care plan goals to the hospital." The Administrator, Director of Nursing and Regional Director of Clinical Services were informed of the finding on 12/12/2019 at 6:55	F 622		

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F 622	Continued From page 23 p.m. at the pre-exit meeting. The facility did not present any further information about the finding.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge,	F 623		

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F 623	Continued From page 24 under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder	F 623		

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F 623	Continued From page 25 established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to notify a representative of the Office of the State Long-Term Care Ombudsman of discharges to the hospital for 6 residents (Residents #63, #27, #71, #61, #37 and #62) of 43 residents in the survey sample. This deficiency is cited as Past Non-Compliance. The findings included: On 12/12/19 at approximately 3:13 PM an interview was conducted with the Corporate Nurse Consultant concerning the above. She stated, "Ombudsman notification will fall under our past non compliance." A document was received shortly thereafter concerning discharge	F 623	Past noncompliance: no plan of correction required.	

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notices not being sent to the local state ombudsman by the previous director of social services for September or October. Corrective Action: The discharge notices will be sent to the ombudsman for those not previously sent. The Ombudsman was notified and he did confirm that he had not received notices for the past couple of months, but said that he is fine with us sending over a spread sheet monthly. How will the facility identify other like residents that have the potential to be affected and what corrective action will be done? An audit was completed of past residents to see if the notices were sent, those not sent are being sent to the ombudsman. What will you do to prevent this from reoccurring or what systematic change will you implement? The spread sheet will be reviewed monthly. How will you monitor and maintain ongoing compliance? The discharge spreadsheets will be reviewed in the monthly QAPI meeting to ensure they are being completed. QAPI: The issue was discussed on 12/06/19 as the new director of social services discovered that the notices had not been sent for the previous months.

1. Resident #63 was originally admitted to the facility on 05/27/2017. Resident #63 was discharged to the hospital on 10/08/2019 and readmitted to the facility on 10/10/2019.

On 12/11/2019 at approximately 5:02 p.m., an interview was conducted with the Director of Social Services and when he was asked if the Ombudsman was notified of Resident #63's discharge to the hospital on 10/08/2019, the Director of Social Services stated, "I've only been here in this position for about two weeks and I contacted the previous Social Worker concerning discharge notices and she stated that she had

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faxed the list of residents who had been discharged in September and October to the Ombudsman but she did not have confirmation that they were sent to the Ombudsman. Going forward I will obtain confirmations when the Ombudsman is made aware of discharges."

The Administrator, Director of Nursing and Regional Director of Clinical Services was informed of the finding on 12/12/2019 at 6:55 p.m. at the pre-exit meeting. The facility did not present any further information about the finding.
2. Resident #27 was admitted with diagnoses of dyspnea, gastro-esophageal reflux disease, emphysema, anxiety, atrial fibrillation and chronic obstructive pulmonary disease.

Resident #27 was discharged to the hospital on 08/29/19. There were no clinical records indicating the facility staff contacted the State Long Term Care Ombudsman of the discharge.

During an interview on 12/11/19 at 11:10 A.M. with the facility's Social Worker, he stated, The facility had not contacted the State Long Term Care Ombudsman regarding discharge to the hospital for Resident #27.

3. Resident #71 was originally admitted to the facility on 12/19/14 and re-admitted on 08/19/19. Diagnosis for Resident #71 included but not limited to Essential Hypertension and Major Depressive Disorder.

The Discharge MDS assessment was dated for 08/15/19 - discharged with return anticipated.

On 08/15/19, according to the facility's documentation, Resident #71 was sent to the

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local Emergency Room (ER). Resident picked up at 6:05 PM and daughter notified right after.

On 12/12/19 an interview was conducted with the facility Director of Social Services (Other Staff #1). He stated that Resident #71's name was not on the list that was sent out to the local ombudsman.

A pre-exit meeting was held with the Administrator, Director of Nursing and Corporate Nurse Consultant on 12/12/19 at approximately 3:05 p.m. No further comments were made.

4. Resident #61 was admitted to the facility on 4/16/19 and readmitted on 11/30/19 with diagnoses that included but were not limited to spinal cord compression, dependence on ventilator, trachesostomy and gastrostomy status (feeding tube).

Review of Resident #61's clinical record revealed that she was transferred to the hospital on 8/9/19. There was no evidence that the long term care ombudsman was made aware of this transfer on 8/9/19.

Review of Resident #61's clinical record revealed that she had been transferred to the hospital for a second time on 11/23/19. There was no evidence that the long term care ombudsman was made aware of this transfer on 11/23/19.

On 12/11/19 at 3:36 p.m., an interview was conducted with OSM (other staff member) #1, the Director of Social Work. When asked who was responsible for notifying the long term care ombudsman when a resident is sent out to the hospital for an acute care transfer, OSM #1

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F 623	Continued From page 29 stated that the social worker was responsible for notifying the long term care ombudsman on a monthly basis of all discharges including acute transfers to the hospital. OSM #1 stated that he had only been employed with the facility for approximately two weeks. OSM #1 stated he was also in training the first week. OSM #1 stated that the only list of discharges he could find from the previous social worker was from March of 2019. On 12/11/19 at 4:51 p.m., OSM #1 confirmed that he could find evidence that the long term care ombudsman was notified when Resident #61 was sent to the hospital on 8/9/19 and 11/23/19. On 12/12/19 at the pre-exit meeting (6:55 p.m.) ASM (administrative staff member) #1, the Administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the Regional Director of Clinical Services were made aware of the above concerns. No further information was presented prior to exit. 5. Resident #37 was admitted to the facility on 1/17/15 and readmitted on 9/23/19 with diagnoses that included but not limited to persistent vegetative state, post stroke, dependence on ventilator, tracheostomy and gastrostomy status (feeding tube). Review of Resident #37's clinical record revealed that she was sent out to the hospital on 9/19/19. There was no evidence that the long term care ombudsman was made aware of this transfer on 9/19/19. On 12/11/19 at 3:36 p.m., an interview was conducted with OSM (other staff member) #1, the	F 623		

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Director of Social Work. When asked who was responsible for notifying the long term care ombudsman when a resident is sent out to the hospital for an acute care transfer, OSM #1 stated that the social worker was responsible for notifying the long term care ombudsman on a monthly basis of all discharges including acute transfers to the hospital. OSM #1 stated that he had only been employed with the facility for approximately two weeks. OSM #1 stated he was also in training the first week. OSM #1 stated that the only list of discharges he could find from the previous social worker was from March of 2019.

On 12/11/19 at 4:51 p.m., OSM #1 confirmed that he could find evidence that the long term care ombudsman was notified when Resident # 37 was sent to the hospital on 9/19/19.

On 12/12/19 at the pre-exit meeting (6:55 p.m.) ASM (administrative staff member) #1, the Administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the Regional Director of Clinical Services were made aware of the above concerns. No further information was presented prior to exit.

6. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #62's transfer and admission to the hospital on 08/11/19. Resident #62 was originally admitted to the facility on 03/12/18. Diagnosis for Resident #62 included but not limited to acute and chronic respiratory failure with hypoxia.

The Discharge MDS assessments was dated for 08/11/19 - discharged with return anticipated.

An interview was conducted with the Director of Social Worker (DSW) on 12/11/19 at

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F 623	Continued From page 31 approximately 10:00 a.m. He said that he has only been employed at the facility for 2 weeks. The DSW stated, "I have search the entire Social Worker's office and I am unable to provide evidence that the Ombudsman was notified of Resident #62's transfer to the hospital on 08/11/19." A briefing was held with the Administrator, Director of Nursing and Regional Director of Clinical Services on 12/12/19 at approximately 6:53 p.m. The facility did not present any further information about the findings. The facility's policy titled Discharge or Transfer Letter Policy (Revised October 5, 2017). -Policy: The facility will complete discharge letters appropriately and according to all federal, state, and local regulations. -Procedure include but not limited to: E. Social Service or designees will assure the original letter is given to resident or guardian/sponsor, if applicable. -Copies will be sent to Department of Health, Ombudsman Office and filed in the business file and/or scanned into Point Clint Care (PCC) documents tab with administrator/designees signature. -For emergency transfers, one list can be sent to the Ombudsman at the end of month.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		

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F 641	Continued From page 32 by: Based on clinical record review, staff interview and facility documentation the facility staff failed to ensure 1 of 43 residents (Resident #54) in the survey sample received a complete and accurate assessment. The findings included: The facility staff failed to ensure Resident #54's, MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of 11/14/19 was coded correctly under Section N (Medications) for the use of Anti-depressant. Resident #54 was admitted to the facility 1/10/19. Diagnosis for Resident #54 included but not limited to Depression disorder. Resident #54's MDS, an annual assessment with an Assessment Reference Date (ARD) of 11/14/19 coded resident with a BIMS score of 15 out of a possible 15 indicating no cognitive impairment. Review of Resident #54's quarterly MDS with an ARD of 11/14/19 was coded 7 for receiving antianxiety medications and was coded 0 for days receiving antidepressant medications. The section N on the MDS under medications received read as follows: Indicate the number of DAYS the resident receiving the medication during the last 7 days, enter "0" if medication was not received by the resident during the last 7 days. Resident #54's comprehensive care plan documented the resident with use of anti-depressant medication. The goal: will show decreased episodes of sign and symptoms of	F 641	1. Resident #54's section N was coded to reflect antidepressants when the resident was receiving antianxiety medication. The MDS was modified to reflect accurate medication received. 2. Residents receiving anti-anxiety medication are at risk for this. Resident's prescribed anti-anxiety medication who had an MDS completed in the last 60 days will be reviewed for section N accuracy. 3. The MDS Coordinators will be educated by the regional MDS consultant on RAI guidance for section N coding. 4. The DON and/or designee will review section N of the MDS for accuracy 50% for 30 days and 10% for 30 days. The findings and trends will be reported to QAPI monthly for 3 months. An ADHOC QAPI was held 12/18/19 to discuss the plan of correction. 5. Date of Compliance January 7, 2020	1/7/2020

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depression through the next review date (02/17/19). Some of the intervention to manage goal included give antidepressant medications as ordered by the physician. Monitor/document side effects and effectiveness.

The physician order read: Starting on 08/28/19, Celexa 40 mg -give 1 tablet by mouth one time a day for depression.

Review of Resident #54's November 2019, Medication Administration Record (MAR) revealed the medication Celexa was administered daily for daily for the look back period of 7 days for the MDS with an ARD date of 11/14/19.

An interview was conducted with MDS Coordinator #1 on 12/12/19 at approximately 8:17 a.m. She reviewed the MDS with an ARD date of 11/14/19 then reviewed the MAR for November 2019. The MDS Coordinator stated, "The MDS was coded incorrectly." She said the medication Celexa is an antidepressant; not antianxiety medication. She stated, "I will modify the 11/14/19, MDS now."

A briefing was held with the Administrator, Director of Nursing and Regional Director of Clinical Services on 12/12/19 at approximately 6:53 p.m. The facility did not present any further information about the findings.

CMS's RAI Version 3.0 Manual (Chapter 1: Resident assessment Instrument (RAI)

1). 1.3 Completion of the RAI (1) the assessment accurately reflects the resident's status.

Goals: The goal of the MDS 3.0 revision are to

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F 641	Continued From page 34 introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in the nursing home care requested that MDS 3.0 revision focus on improving the tool's clinical utility, clarity, and accuracy.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656	1. It was identified that the care plan for resident #30 did not address the prevention of pressure ulcers despite Braden scale pressure ulcer risk assessment indicating that the resident was at risk for developing pressure ulcers. The interdisciplinary team has reviewed resident #30's care plan to address the prevention of pressure ulcers including updates necessary to reflect the resident's current medical status. The care plan was updated on 12/11/19. 2. Residents requiring a plan of care with pressure ulcers have the potential to need care plan revisions. An audit of current residents at risk for Pressure Ulcers care plans has been completed by the unit managers and/or designee to ensure that all pressure ulcer care plans in the last 30 days have been updated. 3. The SDC will educate all nurses on updating care plans with changes in a timely manner. During morning clinical meeting's nurses notes will be reviewed to ensure that care plans have been updated to reflect the changes accurately. 4. The unit managers and/or designee will complete a 100% audit of 24 hour reports for care plan updates 5 times a week for 12 weeks. An ADHOC QAPI was completed on 12/18/19 to discuss the deficient practice and the POC that was put in place. The findings of the audits will be reviewed monthly in QAPI for 3 months. 5. Date of Compliance January 7, 2020	1/7/2020

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F 656	Continued From page 35 (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 observations, clinical record review, staff interviews and facility documentation, the facility staff failed to develop a care plan for the prevention of pressure ulcers/injury for 1 of 43 residents (Resident #30) in the survey sample. The findings include: Resident #30 was admitted to the facility on 9/19/19 with diagnoses that included peripheral vascular disease (PVD), right below the knee amputation (BKA), *unstageable left heel pressure ulcer, type 2 diabetes, stage 3 renal disease, stroke and Alzheimer's disease. Resident #30 was readmitted to the nursing facility on 10/15/19 with additional diagnoses that included post fall, urinary tract infection (UTI), generalized muscle weakness and gastro-esophageal reflux disease (GERD). *According to the NPUAP (National Pressure Ulcer Advisory Panel)/NPIAP (National Pressure Injury Advisory Panel) an unstageable pressure	F 656		

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ulcer/injury is an obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough (slough is non-viable tissue comprised of dead white blood cells, fibrin, cellular debris and liquefied devitalized tissue and requires debridement) or eschar (eschar is composed of necrotic granulation tissue, muscle, fat, tendon or skin. Eschar is used to describe leathery, dry hard eschar tissue). If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar should not be moved on an ischemic limb or heel (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5098472/).

Resident #30's Admission Minimum Data Set (MDS) assessment dated 9/26/19 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 00 out of a possible score of 15 which indicated the resident was severely impaired in the necessary skills for daily decision making. The resident was not coded to reject care to include activities of daily living (ADL) assistance. The resident required extensive assistance from one staff for bed mobility (how the resident moves to and from a lying position, turns side to side, and positions body while in bed or alternative sleep furniture). The resident was assessed totally dependent on two staff for transfers, dressing and personal hygiene and bathing. She was coded totally dependent on one staff for locomotion on the unit and toilet use. The resident used a manual wheelchair as the primary mobility device and was dependent on staff actively propel the resident in the wheelchair. The resident was coded to require set up and supervision from one staff for eating. The resident was assessed at risk for the development of

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pressure ulcers and had one unhealed unstageable pressure ulcer, and no venous or arterial ulcers. Pressure reducing devices for the bed was coded, as well as pressure ulcer care, and nutritional and hydration intervention to manage skin problems. The resident was assessed always incontinent of bowel and bladder. The resident was 5 feet 6 inches tall and weighed 171 pounds. She was not terminal or on hospice care.

Resident #30's 5 day scheduled assessment dated 10/18/19 coded a change in bed mobility to require the assistance of two staff.

Resident #30 was not care planned for the prevention of pressure ulcers although she was assessed upon admission, as well as on the Braden Scale Pressure Ulcer Risk assessments to be at risk for them.

The care plan dated 10/15/19 identified Resident #30 had actual unstageable pressure ulcers on the left heel and left toe. This care plan was revised on 12/11/19 for an acquired unstageable pressure ulcer on the sacrum.

The Braden Scale Pressure Ulcer Risk Assessments dated 9/26/19 indicated the resident was at moderate risk for the development of pressure ulcers with a score of 14, on 10/3/19 at low risk with a score of 15, on 10/22/19 with a score of 14, on 10/29/19 at very high risk with a score of 9, on 11/5/19 at high risk with a score of 12 and on 12/6/19 at very high risk with a score of 9.

On 12/10/19 during the orientation/screening of the residents on North 4 at 11:00 a.m., Resident

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#30 was observed in a blue geri-lounger with pillows wedged in the chair on each side of the resident. The resident remained in the chair until 2:30 p.m. It was not known how long the resident was up in the chair prior to start of this observation, at 11:00 a.m. The resident was wearing a brief and a thin piece of *Dycem was in the seat of the chair, as shown to this surveyor by a Certified Nursing Assistant (CNA). The nurse's notes dated 12/11/19 at 2:22 a.m. indicated that Resident #30 was in the chair when the nurse came on her shift at 7:00 p.m.

*Dycem® is a non-slip, rubber-like plastic material used to stabilize surfaces. Reusable. Cut to most any size or shape with scissors. Cleans with soap and water. Matting is 1/32" thick. Pads are 3/16" thick. Not made of natural rubber latex (https://Dycem-ns.com/). Dycem does not provide pressure relief.

The care plans presented on 12/12/19 at approximately 10:00 a.m. did not include a care plan with goals and approaches to prevent pressure ulcers/injury for Resident #30.

On 12/12/19 at 6:53 p.m., a debriefing was held with the Administrator, Director of Nursing, Regional Director of Clinical Services and Regional Administrator. No further information was provided prior to survey exit.

The facility policy continued: "The first step in prevention will be through identification of the resident at risk of developing pressure ulcers. This will be followed by implementation of appropriate individualized interventions and monitoring for the effectiveness of the interventions... Monitor every shift to ensure that

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F 656	Continued From page 39 measures are in place as specified on the care plan to prevent skin breakdown..." According to the Joint Commission, they support the following pressure ulcer prevention strategies based on the NPUAP's (National Pressure Ulcer Prevention Advisory Panel) also known as NPIAP (National Pressure Injury Advisory Panel): *Definition of pressure ulcer/injury-A pressure ulcer/injury is localized damage to the skin and/or underlying soft tissue, usually over a bony prominence. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The injury can present as intact skin or an open ulcer and may be painful. -Multiple disciplines and teams involved in developing and implementing care plans with teamwork, communication and expertise involved in developing and implementing the care plan, therefore improvement in pressure injury prevention, optimizing overall care and increasing attention to these issues can prevent the next pressure injury and save the next patient. Prioritize and address identified issues. Make sure they are aware of the plan of care and that all care is documented in the patient's record. Retrieved from https://www.jointcommission.org>Quick_Safety_Issue_25_July_20161Based on observations, clinical record review, staff interviews and facility documentation, the facility staff failed to develop a care plan for the prevention of pressure ulcers/injury for 1 of 43 residents (Resident #30) in the survey sample.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

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F 657	Continued From page 40 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review the facility staff failed to revise the comprehensive care plan to reflect the resident's current weight bearing status for 1 of 43 residents in the survey sample, Resident #49. The findings included: Resident #49 was admitted to the facility on	F 657	1. It was identified that the care plan for resident #49 was not updated to reflect a change in weight bearing status as well as the removal of his external fixator. The care plan was updated on 12/11/19. 2. Residents requiring an update to their care plan due to a change in devices or a change in weight have the potential to be affected by this. A 100% audit of any residents with changes in devices or a change in weight will be reviewed for care plan revision by the unit managers and/or designee to ensure that all changes from the last 30 days have been updated. 3. The SDC will educate nurses on updating care plans with changes in a timely manner. All changes from the previous 24 hours will be reviewed in the morning clinical meeting to ensure that care plans have been updated to reflect the changes accurately. 4. The unit managers and/or designee will complete a 100% audit of 24 hour reports for care plan updates 5 times a week for 12 weeks. An ADHOC QAPI was completed on 12/18/19 to discuss the deficient practice and the POC that was put in place. The findings of the audits will be reviewed monthly in QAPI for 3 months. 5. Date of Compliance January 7, 2020	1/7/2020

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F 657	Continued From page 41 07/25/2019. Diagnoses included but were not limited to, Other Fracture of Right Lower Leg, Subsequent Encounter For Closed Fracture with Routine Healing and Other Fracture of Left Lower Leg, Subsequent Encounter For Closed Fracture with Routine Healing. Resident #49's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 11/06/2019 coded Resident #49 with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #49 as requiring limited assistance of 1 with bed mobility, transfer, walk in room, dressing and toilet use and independent with set up help only with eating, personal hygiene and bathing. On 12/12/2019 at approximately 10:00 a.m., review of Resident #49's clinical record revealed the following: Review of Resident #49's comprehensive care plan revealed focus areas and is documented as follows: "(Resident Name) has an ADL (Activity of Daily Living) Self Care Performance Deficit r/t (Related To) inability to bear weight to BLE (Bilateral Lower Extremities)." Date Initiated: 08/07/2019 Revision on : 08/08/2019; "Alteration in musculoskeletal status r/t ORIF (Open Reduction Internal Fixation) to bilateral ankles and NWB (Non-Weight Bearing) orders." Date Initiated: 08/07/2019 Revision on: 08/13/2019; "(Resident Name) is at risk for falls due to BLE Fracture and presence of External Fixators." Date Initiated: 08/07/2019 Revision on: 10/22/2019; "(Resident Name) has acute pain r/t Bilateral Ankle Fracture and External Fixators."	F 657		

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F 657	Continued From page 42 Date Initiated: 08/07/2019 Revision on: 10/22/2019. Review of Resident #49's Physician Order Listing Report revealed the following: "Bilateral Fixator removed via (Name of Hospital abbreviation). Please have therapy eval (evaluate) post surgery x1. One time only for Post Surg (Surgery) for 1 Day." Order Status: Completed Revision Date: 10/28/2019 Last Order Date: 10/28/2019. Review of Resident #49's Physician Orders dated 11/12/2019 revealed the following: "1. Please apply bilateral canvas lace up ankle braces;" 2. "May weight bear to tolerance." ..... Review of Resident #49's Physician Order Listing Report revealed the following: "Non-Weight Bearing To Bilateral Lower Extremities every shift." Order Status: "Discontinued" Revision Date: 11/13/2019 Last Order Date: 08/23/2019. On 12/12/2019 at 12:55 p.m., an interview was conducted with Registered Nurse (RN) #1, MDS Coordinator, was asked to review the residents current orders and comprehensive care plan. When asked if the residents comprehensive care plan reflected the residents current status, MDS Coordinator stated, "No, the care plan needs to be updated. (Resident Name) does not have external fixators and his weight bearing status has changed." When asked if the residents ankle braces should be care planned, MDS Coordinator stated, "Yes." When asked what is the purpose of a comprehensive care plan, Licensed Practical Nurse #2, MDS Coordinator, stated, "The care plan serves as a blue print for nursing."	F 657		

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F 657	Continued From page 43 On 12/12/2019 at 1:30 p.m., during briefing an interview was conducted with the Director of Nursing (DON), when she was asked what her expectations were of the MDS Coordinators updating comprehensive care plans, DON stated, "I expect that the care plan will reflect the residents current status." The Administrator, Director of Nursing and Regional Director of Clinical Services was informed of the finding on 12/12/2019 at 6:55 p.m., at the pre-exit meeting. The facility did not present any further information about the finding.	F 657		
F 677 SS=D	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 observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide fingernail care to a dependent resident for one of 43 residents in the survey sample, Resident #52. The findings included: Resident #52 was admitted to the facility on 5/4/15 with diagnoses that included but were not limited to post stroke, weakness following cerebrovascular disease (stroke) and diabetes type two. Resident #52's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 11/11/19. Resident #52 was coded as	F 677	1. It was identified that resident #52's required staff assistance for ADL care to include nail care. ADL care was immediately provided. 2. Residents requiring assistance with ADL care are at risk for this. A 100% audit has been completed by the unit managers and/or designee of all dependent residents to ensure that ADL and nail care have been provided. 3. Nursing staff will be educated by the SDC on providing ADL care and nail care for dependent residents. 4. Audits will be conducted weekly by the unit managers and/or designee of 100% of dependent residents weekly for 3 months to ensure grooming and hygiene is completed. An ADHOC QAPI was completed 12/18/19. The findings and trends will be reported to QAPI monthly for 3 months. 5. Date of Compliance January 7, 2020.	1/7/2020

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being moderately impaired in cognitive function scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #52 was coded in Section G "Functional Status" as having impairments to one side of his upper and lower extremities.

On 12/10/19 at 11:24 a.m., an interview was conducted with Resident #52. Resident #52 had stated that he wanted his finger nails cut and that staff were aware. Resident #52 could not state who he expressed his concern to. Resident #52 also stated that he was not sure how long it had been since his nails were cut. Observation of Resident #52's nails was also conducted. Resident #52's finger nails to both hands were approximately 1/2 inch long. Resident #52 also stated that he had weakness to his right arm and sometimes wore a brace.

On 12/11/19 at 10:42 a.m., a second observation was made of Resident #52's fingernails. His fingernails were still approximately 1/2 inch long. A nursing assistant had just left Resident #52's room. Resident #52 stated that he was just dressed by the aide for his appointment soon.

Review of Resident #52's ADL (activities of daily living) care plan dated 9/2/19 documented the following: "The resident has an ADL self care performance deficit related to weakness following cerebrovascular accident...check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse."

Review of Resident #52's December 2019 CNA (Certified Nursing Assistant) - ADL tracker form revealed that Resident #52 frequently refused bath days but would accept partial baths. There

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F 677	Continued From page 45 was no evidence that nail care was provided. Review of Resident #52's clinical record failed to evidence that he recently refused fingernail care. On 12/11/19 at 3:05 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. When asked if Resident #52 was able to cut his own fingernails, LPN #1 stated that he wasn't. When asked who was responsible for ensuring fingernails were cut, LPN #1 stated that if a resident was diabetic, nurses were responsible for providing nail care. LPN #1 stated that if Residents are not diabetic, the CNAs would offer and perform nail care during baths, and showers as part of ADL care. LPN #1 stated that nurses should also offer whenever they see that fingernails are long. When asked if Resident #52 had recently requested for his nails to be cut, LPN #1 stated that he usually tells staff when he wants to see podiatry. When asked if she had Resident #52 that day, LPN #1 stated that she had worked with Resident #52 since 7 a.m. that morning. When asked if she noticed his nails, LPN #1 stated his hands were underneath the blanket and that she didn't check his nails. When asked the process if a resident refuses nail care, LPN #1 stated that she would make several attempts to offer nail care and document in a nursing note if the resident continues to refuse care. On 12/11/19 at 3:13 p.m., LPN #1 followed this writer to Resident #52's room. LPN #1 confirmed that his nails were long. At that time Resident #52 stated that he has asked a staff member the day prior (12/10/19) to cut his nails and no one did. He could not recall who he had told.	F 677		

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F 677	Continued From page 46 On 12/11/19 at 3:19 p.m., an interview was conducted with CNA #1, Resident #52's nursing aide. When asked who was responsible for providing fingernail care, CNA #1 stated that the nursing aides were responsible if the resident was not diabetic. CNA #1 stated that they will offer weekly to trim nails if needed and try to ensure they are clean on a daily basis. CNA #1 stated that she did not notice Resident #52's nails that day. CNA #1 stated that she did not offer to cut his nails that day but that he was also diabetic. On 12/12/19 at 10:45 a.m., an interview was attempted with the CNA who worked 12/10/19. She could not be reached. On 12/12/19 at 11:41 a.m., an interview was attempted with the nurse who worked 12/10/19. She could not be reached. On 12/12/19 at the pre-exit meeting (6:55 p.m.) ASM (administrative staff member) #1, the Administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the Regional Director of Clinical Services were made aware of the above concerns. No further information was presented prior to exit. Facility policy, "Nail Care," documented in part, the following: "Nursing staff will administer nail care in order to provide cleanliness and prevent infection."	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		

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F 686	Continued From page 47 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews and facility documentation review, the facility staff failed to develop and implement preventative measures to prevent the formation of a new pressure ulcer to an at risk resident prior to identification at an advanced stage, for 1 or 43 residents (R#30) in the survey sample. Resident #30's sacral/coccyx pressure ulcer was first identified on 12/6/19 by the nursing staff as an unstageable pressure ulcer. The findings include: Resident #30 was admitted to the facility on 9/19/19 with diagnoses that included peripheral vascular disease (PVD), right below the knee amputation (BKA), *unstageable left heel pressure ulcer, type 2 diabetes, stage 3 renal disease, stroke and Alzheimer's disease. Resident #30 was readmitted to the nursing facility on 10/15/19 with additional diagnoses that included post fall, urinary tract infection (UTI), generalized muscle weakness and gastro-esophageal reflux disease (GERD). The resident was a full code. She was not terminal or	F 686	1. Resident #30 had a pressure ulcer that was identified at an advanced stage. The resident was admitted to hospice due to end stage dementia and failure to thrive. Preventative measures are in place based on physician's recommendation. 2. Residents who have been identified utilizing the braden scale are at risk for this. A full house 100% skin sweep was performed, Braden assessments were completed on all residents and a review of all surfaces for appropriate pressure redistribution device/surface was completed. 3. Nursing staff will be educated on bi-weekly skin assessment process. Nursing staff will be educated on identifying changes in skin condition. Nursing staff will be educated on the reporting process for any change in skin condition. Nursing staff and CNA's will be educated on the completion of shower sheets per Saber process. 4. A 100% audit of all bi-weekly skin assessments and shower sheets for completeness and accuracy has been completed by the DON and/or designee. All bi-weekly skin assessments and shower sheets will be audited 3 times a week for 3 months. An ADHOC QAPI was held 12/16/19 to discuss the POC. All findings will be reviewed monthly at QAPI for 3 months. 5. Date of Compliance January 7, 2020	1/7/2020

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F 686	Continued From page 48 on hospice care. *According to the NPUAP (National Pressure Ulcer Advisory Panel)/NPIAP (National Pressure Injury Advisory Panel) an unstageable pressure ulcer/injury is an obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough (slough is non-viable tissue comprised of dead white blood cells, fibrin, cellular debris and liquefied devitalized tissue and requires debridement) or eschar (eschar is composed of necrotic granulation tissue, muscle, fat, tendon or skin. Eschar is used to describe leathery, dry hard eschar tissue). If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar should not be moved on an ischemic limb or heel (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5098472/). Resident #30's Admission Minimum Data Set (MDS) assessment dated 9/26/19 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 00 out of a possible score of 15 which indicated the resident was severely impaired in the necessary skills for daily decision making. The resident was not coded to reject care to include activities of daily living (ADL) assistance. The resident required extensive assistance from one staff for bed mobility (how the resident moves to and from a lying position, turns side to side, and positions body while in bed or alternative sleep furniture). The resident was assessed as totally dependent on two staff for transfers, dressing and personal hygiene and bathing. She was coded totally dependent on one staff for locomotion on the unit and toilet use. The resident was coded to require set up and	F 686		

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F 686	Continued From page 49 supervision from one staff for eating. Resident # 30 was assessed as at risk for the development of pressure ulcers and had one unhealed unstageable pressure ulcer, and no venous or arterial ulcers. Pressure reducing devices for the bed was coded, as well as pressure ulcer care, and nutritional and hydration intervention to manage skin problems. The resident was assessed as always incontinent of bowel and bladder. The resident was 5 feet 6 inches tall and weighed 171 pounds. Resident #30's 5 day scheduled assessment dated 10/18/19 coded a change in bed mobility to require the assistance of two staff. The resident weight had increased to 187 pounds. The care plan dated 10/15/19 identified ADL, self care performance deficit related to Alzheimer's dementia and right BKA and history of stroke as a focus areas. The goals set by the staff for the resident was that the resident would not decline in current level of function and that she would be free from the signs and symptoms of complications from the stroke. Some of the approaches the staff would use to accomplish these goals included observe skin for redness, open area, scratches, cuts, bruises and report changes to nurse per protocol and prn (as needed) and out of bed as tolerated. The care plan indicated the resident was totally dependent on staff for positioning and repositioning. The care plan dated 10/15/19 identified Resident #30 had a left heel, left toe unstageable pressure ulcer and was revised on 12/11/19 for an acquired unstageable pressure ulcer on the sacrum. The goal set by the staff was that the resident's pressure ulcer would show signs of	F 686		

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healing and remain free of infection. The approaches to accomplish this goal included medications and supplements to promote wound healing, serve diet as ordered and monitor intake and record and pressure relieving/reducing device (mattress). The resident was not care planned to have significant weight loss.

Resident #30 did not have a plan of care for the prevention of pressure ulcers even though she was assessed upon admission, as well as on the Braden Scale Pressure Ulcer Risk assessments, to be at risk for them.

The Braden Scale Pressure Ulcer Risk Assessment dated 9/26/19 indicated the resident was at moderate risk for the development of pressure ulcers with a score of 14 based on the following (this assessment tool did not take into account existing pressure ulcers-the unstageable left heel upon admission):

-The resident could not always communicate discomfort or the need to be turned; or, had some sensory impairment which limits ability to feel pain or discomfort in one or two extremities.
-The resident was chairfast in wheelchair.
-Rarely moist-skin usually dry, linen requires changing at intervals.
-The resident was completely immobile and did not make even slight changes in body or extremity position without assistance.
-The resident rarely eats a complete and generally eats only half of the food offered.
-Potential problem with friction or shearing. Moves feebly and during a move skin probably slides to some extent against sheets, chair, restraints or other devices.

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F 686	Continued From page 51 The Braden Scale Pressure Ulcer Risk Assessment dated 10/3/19 indicated the resident was at low risk with a score of 15 for the development of pressure ulcers based on the following changes: -The resident occasionally moist, requiring an extra linen change at least once a day. -Mobility is very limited, makes occasional slight changes in body position, but unable to make frequent or significant changes independently. -Nutrition is adequate, eats over half of most meals. The Braden Scale Pressure Ulcer Risk Assessment dated 10/22/19 indicated the resident was at moderate risk for the development of pressure ulcers with a score of 14 based on the following changes: -Resident requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction. The Braden Scale Pressure Ulcer Risk Assessment dated 10/29/19 indicated the resident was at very high risk for the development of pressure ulcers with a score of 9 based on the following changes: -Completely limited to painful stimuli, due to diminished level. -Constantly moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	F 686		

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F 686	Continued From page 52 The Braden Scale Pressure Ulcer Risk Assessment dated 11/5/19 indicated the resident was at high risk for the development of pressure ulcers with a score of 12 based on the following changes: -Slightly limited in sensory perception, responds to verbal commands, but cannot always communicate discomfort or the need to be turned; or, has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities. The Braden Scale Pressure Ulcer Risk Assessment dated 12/6/19 indicated the resident was at very high risk for the development of pressure ulcers with a score of 9 based on the following changes: -Completely limited to painful stimuli. -Very moist, skin is often, but not always moist. Linen must be changed at least once a shift. -Completely immobile, does not make even slight changes in body or extremity position without assistance. -Rarely eats a complete meal, eats half of food offered. Resident #30 had physician orders dated 9/21/19 for Prostat (protein supplement for wound healing) once a day and increased to twice a day on 11/14/19, and a multi-vitamin once a day ordered on 9/19/19, changed to Theragran-M (multi-vitamins with minerals). On 12/10/19 during the initial screening of the residents on North 4 at 11:00 a.m., Resident #30 was observed in a blue geri-lounger with pillows	F 686		

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wedged in the chair on each side of the resident. The resident remained in the chair until 2:30 p.m. It was not known how long the resident was up in the chair prior to start of this observation, at 11:00 a.m. The resident was wearing a brief and a thin piece of *Dycem was in the seat of the chair, as shown to this surveyor by a Certified Nursing Assistant (CNA). The nurse's notes dated 12/11/19 at 2:22 a.m. indicated that Resident #30 was in the chair when the nurse came on her shift at 7:00 p.m.

*Dycem® is a non-slip, rubber-like plastic material used to stabilize surfaces. Reusable. Cut to most any size or shape with scissors. Cleans with soap and water. Matting is 1/32" thick. Pads are 3/16" thick. Not made of natural rubber latex (https://Dycem-ns.com/). Dycem does not provide pressure relief.

The Bi-Weekly skin checks that were presented to this surveyor, performed by a licensed nurse, identified the admitted (9/19/19) left unstageable heel ulcer, but NO NEW PRESSURE ULCERS per the skin checks on 10/21/19, 10/24/19, 10/26/19, 10/28/19, 10/29/19, 11/3/19, 11/5/19, 11/7/19, 11/19/19, 11/21/19, 11/25/19, 11/28/19, 12/1/19, 12/3/19, 12/6/19 (timed at 7:25 p.m.). On 12/9/19 (timed at 6:20 p.m.) the coccyx pressure ulcer was recorded.

The nurse's notes dated 12/6/19 at 5:09 p.m. indicated a "new pressure wound...Stage: unst (unstageable) wound location coccyx; length 4.0 centimeters (cm), width 3.5 cm; depth 0.1 cm; area is in house acquired. Skin impairment was not present upon admission. 12/6/19 drainage type: No drainage wound has slough. No odor periwound (perimeter of the wound) appearance

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is red...Treatment: cleanse coccyx area with wound cleanser and apply *Santyl and cover..." This nurse's note was signed by Licensed Practical Nurse (LPN) #8.

*Santyl is a topical debridement agent Collagenase Santyl® Ointment is a sterile enzymatic debriding ointment which possesses the unique ability to digest collagen in necrotic tissue (https://www.rxlist.com/santyl-drug.htm#description).

On 12/11/19 at 12:23 p.m., LPN #8 performed wound care to the sacral/coccyx pressure ulcer assisted by the Registered Nurse (RN) Supervisor #2. The sacral/coccyx wound bed exhibited light brown/yellowish slough with redness around the perimeter of the wound. The resident had a large soft dark brown liquid stool that had oozed into and under the dressing prior to its removal, as well as in the front peritoneal area and vaginal folds. The RN Supervisor #2 used a basin of soapy water and many wash cloths and towels to remove the exorbitant amount of stool prior to performing the dressing change. The resident was also observed dribbling urine throughout the dressing change procedure with continued oozing of stool.

On 12/11/19 at 4:00 p.m., an interview was conducted with the Director of Nursing (DON). The Weekly Wound Assessments were reviewed with her and at this time an inquiry was made regarding any further information, documentation that would refute that the sacral wound pressure ulcer was first identified by the nursing staff at an advanced stage on 12/6/19. She pointed to the Weekly Wound Assessment document date of

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12/6/19 that indicated the pressure ulcer was unstageable, in house acquired with slough in the wound bed and no documentation to support otherwise.

On 12/12/19 at 1:00 p.m., an interview was conducted with the North 4 RN Unit Manager. When asked if she had any other documentation that showed there was an area on the resident's sacrum prior to it being assessed as unstageable on 12/6/19. She stated copies of skin assessments, wound assessments and nurse's notes were what she had to go on and there was nothing she could find identified prior to 12/6/19 on the resident's sacrum/coccyx and that they were given to this surveyor. When asked if it was acceptable to first identify a pressure ulcer at an advanced stage, she responded, "Not preferable." She stated on 10/1/19, Resident #30 was placed on a specialty mattress 10/1/19, but there was no pressure reduction of relieving device/cushion placed in her geri-chair. The Unit Manager stated, "We only use a piece of *Dycem to keep her in place in the chair with pillows to wedge on each side of her body otherwise she would wiggle or slide down, she is in a Geri-Chair. We recline her a little." When asked if they consulted Occupational Therapy (OT) for residents with positioning challenges, to come up with something that would fit in the Geri-chair that would provide pressure relief/reduction to which she responded, "No we haven't."

During the above interview, the North 4 RN Unit Manager stated the nursing staff get the resident up every day for a couple of hours and she is checked every 2 hours for incontinence. She stated the CNAs were to report all changes in skin integrity to the licensed nurse. When asked

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if there were any "Stop and Watch" forms on file filled out by any CNAs that would evidence any areas or changes in the resident's sacrum/coccyx before 12/6/19, the Unit Manager stated there were not any and she knew that when CNA #3 saw the pressure area on 12/6/19, she did not fill one out, but went straight to the nurse to let her know.

On 12/12/19 at 1:25 p.m., during an interview with LPN #8, she stated the wound was in house acquired and first found by Certified Nursing Assistant (CNA) #3. She stated, "(CNA #3's name) came to tell me when she checked the resident's brief, she found this pressure area." She stated she is routinely assigned to Resident #30 and it was the first she heard or knew about an area on the resident's coccyx. She stated she assessed the resident, called the physician with the assessment of the wound (described in the aforementioned nurse's note dated 12/6/19 at 4:10 p.m.) and received orders for treatment.

The verbal Physician orders were verified dated 12/6/19 to cleanse the wound with with wound cleanser or normal saline, pat dry, apply Santyl, cover with a dry sterile dressing daily and PRN until healed as needed for wound care, and every shift for pressure injury.

Record review revealed the Physician's Assistant (PA) examined the wound on 12/11/19 and ordered that the same dressing change procedure be followed as ordered on 12/6/19 except that wound be cleansed with normal saline, not wound cleanser and a nickel thick amount of Santyl be applied to the wound bed.

On 12/12/19 at 2:00 p.m., an interview was

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conducted with CNA #3. She stated, "I was pulled to the unit at 1:00 p.m. that day (12/6/19). I wasn't working over there (North 4). When I turned her over to check her to see if she was wet that was when I saw this large area in the middle of her bottom. I went immediately to (LPN #8's name) and told her."

The CNA that had the resident on 12/5/19 from 7:00 p.m. to 7:00 a.m. (12/6/19) did not respond to the surveyors telephone calls prior to survey exit.

On 12/12/19 at 4:21 p.m., a telephone interview was conducted with CNA #5. She stated she took care of the resident on Tuesday 12/10/19 from 7:00 a.m. to 7:00 p.m. and stated she gets her up in the chair daily. She stated the resident did not have a pressure relief cushion, just a sheet of Dycem to keep her in place. She stated, "The resident did not have a pressure ulcer on her bottom when she came in. She came in with that heel, but there was nothing on her bottom when I had her on 12/5/19 from 7:00 a.m. to 7:00 p.m. I checked her every two hours and she was clear. If I see something, I tell the nurse."

On 12/12/19 at 6:00 p.m., the resident was observed in bed and it was asked to see the chair Resident #30 was normally placed in, both RN supervisors #2 and #4 stated the chair was behind the door in the resident's room. It was at this time, this writer validated it was the same chair as previously observed the resident in on 12/10/19 at 11:00 a.m. No cushions, or pressure relief/reduction devices were observed.

On 12/12/19 at 6:53 p.m., a debriefing was held with the Administrator, Director of Nursing,

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F 686	Continued From page 58 Regional Director of Clinical Services and Regional Administrator. Concerns about identification of the sacrum/coccyx pressure ulcer was reviewed with all those in attendance. The Administrative Team concurred that the expectation of the nursing staff would be to check the resident every two hours or as needed for incontinence, provide incontinence care as necessary and reposition at least every two hours, in bed and in the chair. It was also stated and agreed by the Administrative Team in attendance, that the CNAs are to report any changes in skin integrity to the nurse immediately, if found during their checks or care. Additionally, it was stated that the Bi-Weekly skin checks and the one dated 12/6/19 at 7:25 p.m. (after the sacrum/coccyx pressure ulcer was identified) indicated the resident had no new identified skin issues. The observations of the resident were discussed during the debriefing. It was stated by the surveyor that the resident was up in her chair with only a sheet of Dycem and pillows wedged on both sides, which rendered the resident totally immobile, and without a pressure relief device/cushion, placed the resident at an increased risk for breakdown with direct sustained pressure to the coccyx area. The Regional Director of Clinical Services stated that she knew that she could provide information that Resident #30's pressure ulcer could have developed in a few hours. The survey team gave the facility staff the opportunity to present credible evidence that an "unstageable" pressure ulcer could develop within a few hours. The Administrator, DON and Regional Director of Clinical Services returned at 7:30 p.m., but was not able to present any supporting articles or	F 686		

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research that indicated an "unstageable" pressure ulcer could develop in a few hours. The resident was not terminal or in hospice care.

The facility's policy and procedure titled Pressure Ulcer Policy/Wound Management dated as revised on 1/18/17 indicated the following:

"It is the policy of (Name of Health Care Corporation) based on the comprehensive assessment of the resident; the facility must ensure that a resident receives care consistent with professional standards of practice, to prevent pressure ulcer and does not develop pressure ulcers unless the clinical condition demonstrates that they were unavoidable; and that a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing."

The facility policy continued: "The first step in prevention will be through identification of the resident at risk of developing pressure ulcer. This will be followed by implementation of appropriate individualized interventions and monitoring for the effectiveness of the interventions. Upon admission and at least quarterly, resident will be assessed for risk of developing pressure ulcers by utilizing a standardized tool. The Braden score is completed on admission and for the next three weeks (to ensure any change is identified), quarterly, with significant changes in cognition or functional ability or acute illness as determined by facility nursing administration...Assessments are head to toe assessments...Monitoring includes evaluate and document when there are identified changes. Monitor every shift to ensure that

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F 686	Continued From page 60 measures are in place as specified on the care plan to prevent/promote skin breakdown. Twice a week, on bath/shower days, the nursing assistant will report any reddened and/or areas of concern to the licensed nurse. The licensed nurses will completed a head to toes body review as well. This head to toe body review in addition to the nursing assistant's skin review...The interdisciplinary team will review residents with pressure ulcers during the weekly NAR (Nutritional at Risk) committee/resident review committee. The DON/designees will report findings to the quarterly Quality Improvement Committee." According to the Joint Commission, they support the following pressure ulcer prevention strategies based on the NPUAP's (National Pressure Ulcer Prevention Advisory Panel) also known as NPIAP (National Pressure Injury Advisory Panel): *Definition of pressure ulcer/injury-A pressure ulcer/injury is localized damage to the skin and/or underlying soft tissue, usually over a bony prominence. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The injury can present as intact skin or an open ulcer and may be painful. -Multiple disciplines and teams involved in developing and implementing care plans with teamwork, communication and expertise involved in developing and implementing the care plan, therefore improvement in pressure injury prevention, optimizing overall care and increasing attention to these issues can prevent the next pressure injury and save the next patient. Prioritize and address identified issues. Make sure they are aware of the plan of care and that all care is documented in the patient's record.	F 686		

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F 686	Continued From page 61 -Risk Assessment should be considered as the starting point. The earlier a risk is identified, the more quickly it can be addressed. -Refine the assessment by identifying other risk factors, including existing pressure injuries and other diseases, such as diabetes and vascular problems. Repeat the assessment on a regular basis and address changes as needed. -Skin Care. Protecting and monitoring the condition of the patient's skin is important for preventing pressure sores and identifying *Stage 1 sores early so they can be treated before they worsen. *A Stage 1 pressure ulcer is intact skin with a localized area of non-blanchable erythema (swelling), which may appear differently in darkly pigmented skin. Presence of blanchable swelling or changes in sensation, temperature or firmness may precede visual changes. -Inspect the skin upon admission and at least daily for signs of pressure injuries. -Assess pressure points. -Clean the skin promptly after episodes of incontinence -Avoid positioning the patient on an area of pressure injury. -Positioning and Mobilization. Immobility can be a big factor in causing pressure injuries. -Turn and reposition at-risk patients, if not contraindicated. -Plan a scheduled frequency of turning and repositioning the patient. -Consider using pressure-relieving devices when placing patients on any support surface (chair and bed or alternate sleeping surfaces). Retrieved from	F 686		

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F 686	Continued From page 62 https //www.jointcommission.org>Quick_Safety_Issue_25_July_20161	F 686		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and clinical record review the facility staff failed to ensure 1 of 43 residents (Resident #35) in the survey sample, who were unable to carry out activities of daily living, received the necessary services to maintain toenail care. The findings included: The facility staff failed to ensure that podiatry services was provided to Resident #35. Resident #35 was admitted to the facility on 09/04/19. Diagnosis for Resident #35 included but not limited to Alzheimer's disease. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 10/23/19 coded the resident on the Brief Interview for Mental Status	F 687	1. It was identified that resident #35 required ADL foot care and podiatry services. ADL care was immediately provided and podiatry assessed and treated the resident on 12/12/19. The resident was added to the podiatry list for further treatment as needed. 2. Residents requiring assistance with ADL foot care and podiatry services are at risk for this. A 100% audit has been completed by the unit managers and/or designee of dependent residents to ensure that ADL care has been provided and that any residents requiring podiatry are added to the podiatry referral list. 3. Nursing staff will be educated by the SDC on providing ADL care and nail care for dependent residents. Nursing staff will be educated on the process for adding residents to the podiatry list. Facility has implemented a change in the manner in which referrals for consultant services, to include podiatry, will be logged via a binder located on each nursing unit. 4. Audits will be conducted weekly by the unit managers and/or designee of 100% of dependent residents weekly for 3 months to ensure grooming and hygiene is completed. The DON and/or designee will conduct weekly audits to ensure the podiatry list is current and residents have been seen. The audit will be done 100% for 12 weeks. An ADHOC QAPI was completed 12/18/19. The findings and trends will be reported to QAPI monthly for 3 months. 5. Date of Compliance January 7, 2020.	1/7/2020

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F 687	Continued From page 63	F 687		

(BIMS) with a score of 06 out of a possible score of 15. which indicated severe cognitive impairment for daily decision-making. Resident #35 was coded total dependence of one with dressing, hygiene, bathing and toilet use, limited assistance of one with transfer and bed mobility with Activities of Daily Living (ADL) care.

Resident #35's comprehensive care plan with a revision date of 09/18/19 documented Resident #35 with ADL self-performance deficit related to Alzheimer's Dementia and muscle weakness. The goal: will improve current level of function through next review date (12/18/19). Some of the intervention/approaches to manage goal included to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse.

An interview was conducted with Resident #35 on 12/11/19 at approximately 9:00 a.m. Resident #35 stated, "My toenails need to be cut but I cannot get one to cut them." The resident also said the staff does not wash my feet; my feet are dirty.

On 12/11/19 at approximately 9:14 a.m., the Unit Manager (UM) and surveyor assessed the resident's toenails. The nurse removed the sock from the resident's left foot with the following observed: all toenails were long, thick and curved to the side. The nurse removed the sock from the right foot; the 1st, 3rd, 4th, and 5th digit were long, thick and curved to the side. The 2nd digit was long, thick and had cured backward almost coming in contact with the top of the toe. The resident asked for the UM to check in between then stated, "They don't wash my feet; my feet are dry and dirty." The nurse assessed in

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F 687	Continued From page 64	F 687		

between resident toes; observed was a brown substance in between the 2nd, 3rd and 4th digit on the left foot and 3rd and 4th digit to the right foot. The nurse was asked if Resident #35 was ever placed on the podiatry list to be seen, she replied, "I don't know but I will make sure she is put on the podiatry list." The nurse was asked, "Does Resident #35 need her toenails cut and trimmed" she replied, "Yes."

On 12/11/19 at approximately 12:35 p.m., the Unit Secretary on Unit 4, stated, "Someone (not sure who) gave me Resident #35's name to have her placed on the podiatry list to be seen because her toenails need to be cut and trimmed." She said this is the first time anyone has every mention to her that Resident #35 required podiatry services.

On 12/11/19 at approximately 1:00 p.m., the Unit Secretary provided a podiatry list for October and November 2019, which did not include Resident #35. The Unit Secretary she had contacted the podiatry office requesting for Resident #35 to be seen as soon as possible. On the same day at approximately 3:10 p.m., the Unit Secretary stated, "The podiatrist will be her tomorrow (12/12/19) to see Resident #35."

On 12/12/19 at approximately 10:50 a.m., an interview was conducted with the Registered Nurse (RN), Nurse Supervisor on North 4 unit. She said the certified nursing assistants should be checking the resident's fingernail and toenails daily while providing ADL care and on their shower days. She said the nurses should be checking the resident's toenails when performing the resident's weekly skin assessments. She said for a resident, who is non-diabetic, the nurses can cut their toenails if they are not too

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F 687	Continued From page 65 thick. Review of Resident #35's clinical record did not reveal refusal of toenail care. Review of Resident #35's current Physician Order Sheet (POS) included the following order but not written until 12/12/19: may see podiatrist as needed. On 12/12/19, according to the clinical record, Resident #35 was seen by the podiatrist on 12/12/19. The progress report included the following documentation: Chief complaint: -Painful, elongated and thicken toenails. -Toenails: thicken. debris, painful, brittle and difficulty walking. -Dermatological: scaly. Diagnosis/Treatment: -Onychomycosis to left and right toenails. -Painful: left and right toenails. -Debrided painful dystrophic nails. Orders written: -Aquaphor ointment. A briefing was held with the Administrator, Director of Nursing and Regional Director of Clinical Services on 12/12/19 at approximately 6:53 p.m. The facility did not present any further information about the findings. The facility did not have a policy directly related to podiatry services or foot care but did provide a policy titled Nail Care (Revision date: 01/2014). -Policy: Nursing staff will administer nail care in	F 687		

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F 687	Continued From page 66 order to provide cleanliness and prevent infection. Definitions: Alzheimer's is the common form of dementia. A progressive disease beginning with mild memory loss possibly leading to loss of the ability to carry on a conversation and respond to the environment (Source: http://www.cdc.gov/aging/aginginfo/alzheimers.htm).	F 687		
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 §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	F 755	1. It was identified that Ativan was stocked in the refrigerator housed in the medication room on the unit without a delivery manifest and/or a control count sheet. The medication was removed and pharmacy contacted for replacement delivery. 2. Any house stock medication stored outside of the Omnicell is at risk for this. Control count sheet was obtained from pharmacy with the new delivery and placed in the unit 3 narcotic book. 3. The SDC will educate nurses on the addition of this count sheet and the process for validating the count sheet each shift. 4. The DON and/or designee will perform 100% audit of house stock Ativan narcotic count sheet weekly for 6 weeks. An ADHOC QAPI was held on 12/18/19 to discuss the POC for this deficiency. The findings and trends will be reported to QAPI monthly for 3 months. 5. Date of Compliance January 7, 2020	1/7/2020

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F 755	Continued From page 67 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 observation and staff interview, the facility staff failed to a system in place to control, account for, and periodically reconcile, the controlled medication Ativan. The findings included: On 12/12/2019 at approximately 10:00 a.m., a tour of the medication storage room on North 3 Unit revealed a small refrigerator which contained an affixed small metal lock box on the bottom base of the refrigerator. LPN (Licensed Practical Nurse) #1 was asked to describe the purpose of the lock box located within the refrigerator. LPN#1 responded, "I'm not going to open that lock box. I don't think there is anything in there." Surveyor asked LPN #1 to open the lock box, revealing six vials of Ativan in the box. LPN #1 was asked to show evidence of accounting for the medication and she stated, "We don't have a system to count it." An interview was conducted with the Director of Nursing on 12/12/2019 at approximately 3:00 p.m. and when asked about the accounting of Ativan on North 3 unit, she replied, "Those are for emergency usage." An interview was held with North 3 LPN #7, the Unit Manager and when asked about the accounting of Ativan on North 3 unit, LPN #7	F 755		

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F 755	Continued From page 68 replied, "The Ativan should have been included with the count." The facility Administrator was informed of the findings during a briefing on 12/12/2019 at approximately 4:45 p.m. On 12/12/2019 at approximately 6:04 p.m., an email from the pharmacy contractor was submitted relaying, Per (Corporation name) request, "I delivered two lorazepam injections for house stock to be used in the event of an emergency ...The pharmacy is in the process of searching for the proof of delivery ticket. I will forward a copy to the community once it has been retrieved." No additional documentation was provided prior to the survey exit. The Facility policy on Inventory Control of Controlled Substances dated 12/01/07 states: 1.2 Facility should ensure that the incoming and outgoing nurses count all Schedule II controlled substances and other medications with a risk of abuse or diversion at the change of each shift or at least once daily and document the results on the "Controlled Substance Count Verification/Shift Count Sheet" set forth in Appendix 15: Shift Verification of Controlled Substances (may also be called "Controlled Substance Disposition Record.) 2. Facility should ensure that facility staff count all Schedule III-V controlled substances in accordance with facility policy and applicable law. 3. Facility should periodically count controlled substances stored in emergency kits,	F 755		

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F 755	Continued From page 69 refrigerators or kept in other storage areas. The Facility policy on Emergency Mediation Supplies dated 12/01/2007 states: 1.3 Facility should maintain a list of inventory in the Emergency Medication Supply in a location easily retrievable for quick reference.	F 755		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of the facility's policy, the facility staff failed to ensure food was stored under sanitary conditions. The finding included	F 812	1. Items were identified in the kitchen that were not labeled and/or dated after being opened in accordance with the facility policy. All items identified were discarded and an audit was completed to ensure that there were no other items unlabeled and/or undated. 2. Residents who consume food prepared in the kitchen are at potential risk for this. 3. The dietary staff will be educated on the policy regarding labelling and dating of food. 4. The kitchen will be audited by the dietary manager and/or designee 5 times a week to ensure that food items are labeled and dated properly. The Administrator and/or designee will audit the kitchen 3 times a week for 4 weeks, 2 times a week for 4 weeks and then 1 time a week thereafter to ensure that all items are being labeled and dated in accordance to the facility policy. The findings and trends will be reported to QAPI monthly for 3 months. 5. Date of Compliance January 7, 2020	1/7/2020

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F 812	Continued From page 70 On 12/10/19 at approximately 10:50 AM an initial tour of the kitchen was conducted with the Food Service Director (FSD). The following was observed during the tour: Located in the walk-in freezer-one opened and not sealed 5 lb. bag (1/2 full) of Chicken tenders with no opened date listed. Located in dry storage one opened bag of Brown Sugar (1/2 full) with no opened date. Located in the kitchen on the shelf was one bag of Red Raspberry Gelatin dessert mix. (1/4 mix left in bag) and one opened bag of Alfredo sauce with no opened date listed. Located in the reach in freezer was one opened, unsealed, and unlabeled bag of frozen vegetables with no opened date. Located in the reach in freezer was a 2 lb opened (sealed) brown bag of french fries with no opened date. The bag was not labeled with what the product was. One opened, 12 ounce bag of dry gravy mix (1/4 full) with no opened date. Policy: Storage of Refrigerated Foods. Date Reviewed: 2/19/19. Date Revised: 2/19/19. Refrigerated items must have a label showing the name of the food and date it should be consumed, or discarded. On 12/11/19 at approximately 5:10 PM an interview was conducted with the Food Service Director (FSD) concerning the opened items listed above. She was asked what should have been done concerning the unlabeled/undated foods? She stated, "They should have been labeled with an opened date." A pre-exit meeting was held with the	F 812		

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F 812	Continued From page 71 Administrator, Director of Nursing and Corporate Nurse Consultant on 12/12/19 at approximately 3:05 p.m. No further comments were made.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight	F 842	1. Resident #335's nurses notes were not available to be reviewed. Resident records are intact from July 1, 2019 with the implementation of a new EMR system. Resident records were reviewed going back to July 1, 2019 to ensure availability. Records from previous company are also available. 2. Residents who have medical records are at risk for this. 3. Medical records coordinator will be educated by the administrator on the facility policy for record retention. 4. 100% audit of all resident records reviewed back to July 1, 2019 completed. As of July 1, 2019 all resident records are available via the EMR system and can be accessed. There is a coordinated plan with prior facility ownership to obtain any records needed prior to July 1, 2019. The findings and trends will be reported to QAPI monthly for 3 months. 5. Date of compliance January 7, 2020	1/7/2020

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F 842	Continued From page 72 activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility staff failed to ensure 1 (Resident #335's) of 43 residents in the survey sample's medical records were readily accessible.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495173	A. BUILDING _____ B. WING _____	C 12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERSIDE HEALTH & REHAB CENTER	249 SOUTH NEWTOWN RD NORFOLK, VA 23502

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F 842	Continued From page 73 The findings included: Resident #335 was admitted to the facility on 11/27/18 with diagnoses of pressure ulcer on the sacral region, unspecified stage and Multiple Sclerosis. Resident #335 was discharged on 11/29/18, therefore a closed record review was attempted. On 12/11/19 at approximately 1:45 PM, the Corporate Nurse Consultant was asked for Resident # 335's clinical record to include nurses notes, MDS (Minimum Data Set), and skin assessments. All requested medical records were received except the nurses notes. The Corporate Nurse Consultant explained that they could only access records from July 1, 2019 forward since the facility was bought out by another company. She stated the previous company did not give them access to the medical records prior to July 1st; the records had to be requested from the prior facility corporation. A pre-exit meeting was held with the Administrator, Director of Nursing and Corporate Nurse Consultant on 12/12/19 at approximately 3:05 p.m. No further information was presented by the facility staff.	F 842		