STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495134	A. BUILDING _____ B. WING _____	R 09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST MANOR NURSING & REHABILITATION	157 ROSS CARTER BOULEVARD DUFFIELD, VA 24244

(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 Medicare/Medicaid revisit survey was conducted 9/10/19 through 9/12/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 111 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents #201 through 211).	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit survey was conducted 9/10/19 through 9/12/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 111 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents #201 through 211).	{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.	F 583		10/10/19

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

Electronically Signed | 10/09/2019

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F 583	Continued From page 1 §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to provide privacy for 1 of 4 residents observed during a medication pass and pour observation, Resident # S2. The findings included The facility staff failed to pull the privacy curtain to provide privacy while administering medications through a peg tube for Resident # S2. On 9/12/19 at 8:47 am, the surveyor was conducting a medication pass and pour observation with LPN # 1 (licensed practical nurse). The surveyor observed that LPN # 1 did	F 583	This plan of correction constitutes the written allegation of compliance for the deficiencies sited.¿ However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly.¿ This plan of correction is submitted to meet requirements established by State and Federal Law. F583 Resident #S2 still resides in the facility. We were unable to correct the deficient action as related to a past observation during medication administration pass. The nurse received education related to	

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F 583	Continued From page 2 not pull the privacy curtain and Resident # S2 was visible to her roommate as LPN # 1 administered medications to Resident # S2 via peg tube. On 9/12/19 at 10:03 am, the surveyor interviewed LPN # 1. The surveyor asked LPN # 1 why she did not pull the privacy curtain during medication administration for Resident # S2. LPN # 1 stated, "I didn't even think about it." "Her husband used to be in the room with her, and he used to like to watch her get her medicine." The person that is in there now is usually in therapy when I give her medication, and I didn't think to pull the curtain." The facility policy on "Resident Privacy" contained documentation that included but was not limited to, ..." Procedure 2. A closed door, drawn curtain, or both, shields the resident from passerby, as well as their roommate." ... On 9/12/19 at 2:30 pm, the administrator, the administrator in training, the director of nursing and the regional director of clinical services were made aware of the findings as stated above. The administrative team was provided the opportunity to ask questions and submit more information to dispute the deficient practice as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 9/12/19.	F 583	providing privacy. All residents with enteral feeding were audited to ensure personal privacy curtain presence and functionality. Staff were provided education by the Director of Nursing or designee on personal privacy The Unit Managers and Director of Nursing are conducting audits on three random nurses weekly for three months to monitor proper personal privacy during G-Tube administration. The Director of Nursing will submit the findings from the audits to monthly QAPI Committee for three months for review and any further recommendations. Director of Nursing/Designee Date of correction: 10/10/2019	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse,	F 609		10/10/19

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F 609	Continued From page 3 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 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 facility document review, staff interview and clinical record review, the facility staff failed to report an allegation of abuse to the appropriate agencies for 1 of 12 residents in the survey sample (Resident #209). The findings included: The facility staff failed to report an allegation of abuse to the appropriate agencies for Resident	F 609	F609 Resident #209's continues to reside in the facility. The incident has been investigated and reported per regulations A review was conducted of the grievance log, and facility wide interviews were conducted with interviewable residents. Residents that are non-interviewable on the secure unit had a skin assessment completed and there were not any	

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F 609	Continued From page 4 #209. Resident #209 was originally admitted to the facility on 5/27/19 with the following diagnoses of, but not limited to anemia, coronary artery disease, high blood pressure, pneumonia, diabetes, arthritis and dementia. This resident was first admitted to a facility in which it was a "sister facility" but was transferred to present facility due to being able to meet the increased needs of this resident in a secure unit due to wandering tendencies and family request. This transfer of this resident occurred on 8/23/19. During the clinical record review by the surveyor on 9/11/and 9/12/19, the following documentation was noted on the Admission/Readmission Evaluation, which was completed on 8/23/19: o" ...During the last 90 days resident had No Falls ... o The resident's cognitive status changed in the last 90 days was answered as No ... o Moderately impaired limited vision, but can identify objects ... o Confined to a chair ... o Balance not steady, only able to stabilize with physical assistance ... o 3 or more medications taken currently or within the last 7 days ... o Memory loss ..." o Resident #209 was also marked as requiring 1 person assist with ambulation, bed mobility, bathing, dressing, eating, toileting, and transfers. The surveyor reviewed the resident's clinical record on 9/11/19 and 9/12/19. During this review, the surveyor noted the following documentation dated and timed for 8/27/19 at 10:57 am which read, "While attempting to get	F 609	reportable issues identified. The Administrator/Designee provided staff training on abuse and reporting requirements. The Administrator/Designee will review resident council meeting minutes monthly for any potential reportable concerns, five random residents will be interviewed to ensure there are no reportable concerns identified weekly for three months. The grievance log will be reviewed weekly to ensure there are not any reportable concerns for three months. . The Administrator/Designee will submit the findings from the reviews to the QAPI Committee for three months for evaluation and any further recommendations. The Administrator/Designee Date corrected: 10/10/2019	

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F 609	Continued From page 5	F 609		

resident dressed and cleaned up for the day, resident started yelling before anyone even touched this resident. No, your not going to beat me up and put more bruises on me! Do not touch me, you guys are mean to me! The resident was left alone for now to rest." The surveyor reviewed the nursing notes after this incident and there was no further documentation on the allegation of abuse.

On 9/11/19 at approximately 4:45 pm, the surveyor asked the administrative team in the end of the day conference if they had any FRI's (Facility Reported Incidents) on Resident #209 for this date. The director of nursing and the regional nurse consultant both stated they were not aware of any FRI's that had been completed concerning this resident. Both stated they would look into this and provide the surveyor with any information that they find.

On 9/12/19 at 9:15 am, the regional nurse consultant, director of nursing (DON) and administrator in training (AIT) were present with the surveyor in the conference room. The regional nurse consultant stated, "I was wondering why you asked us for a FRI on this resident yesterday because all that we were aware of was 2 falls that occurred on 8/26 and 8/27/19. Both the DON and I worked late and read the nurses' notes and that was when we found the allegation of abuse that was documented by the nurse of 8/27/19 at 10:57 am." Both the regional nurse consultant and the DON stated they were not aware of this allegation until they were reviewing the notes last night (9/11/19). The regional nurse consultant stated, "After finding this out, we immediately faxed in a FRI to your office and notified the appropriate

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F 609	Continued From page 6	F 609		

agencies of this allegation." The administrator in training stated that after these measures were taken, the staff was educated on reporting of any allegations of abuse immediately to their supervisor and then follow the chain of command so any allegations that are reported and investigations could be started within 2 hours of being told of an allegation. "We have been doing this as staff was clocking into work last night and following through until all staff are in-serviced on this." The surveyor asked if the nurse that wrote this note was working today. The DON stated, "No, she is on vacation and not on the schedule." The surveyor asked for a copy of the facility's policy on reporting allegations of abuse or neglect. The surveyor also requested a copy of any in services that staff had received in the past year on abuse and neglect of any resident in the facility.

The surveyor was provided with a copy of the facility's policy titled "Virginia Resident Abuse Policy" which read in part, " ...Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy ..."

The administrator in training provided the surveyor with a list of courses that the facility staff are required to have on an annual base. Included in these courses, were the courses on abuse and neglect, who and how to report this to if they ever receive a report of any of this. The surveyor reviewed the documentation on this list and noted there was a completion percentage of 99.12% of staff had completed these annual courses.

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F 609	Continued From page 7 The unit manager for the Memory Care Unit was interviewed on 9/12/19 at approximately 1 pm in the conference room. The surveyor asked if she had received any allegations of abuse in which Resident #209 had reported to a nurse and then that nurse documented the statements in a nurses' note on 8/27/19 at 10:57 am. The unit manager stated, "No one reported this incident to me and I was not aware of it until the DON had shown me the nurses' notes this morning." The surveyor notified the Administrator along with the rest of the administrative team of the above documented findings on 9/12/19 at 3:30 pm. The surveyor asked the administrator if he had been aware of the allegation of abuse that had been documented in the nurses' notes of Resident #209 on 8/27/19 at 10:57 am. The administrator replied, "No one knew of this allegation until my staff was reading over the notes last night and found it." No further information was provided to the surveyor prior to the exit conference on 9/12/19.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		10/10/19

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F 610	Continued From page 8 §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, facility document review and clinical record review, the facility staff failed to immediately start an investigation when 1 of 12 residents in the survey sample alleged abuse by a staff member and failed to report these completed findings within 5 days of the becoming aware of an alleged abuse to a resident in the nursing facility (Resident #209). The findings included: The facility staff failed to immediately investigate an allegation of abuse that was reported to staff by Resident #209 on 8/27/19 at 10:57 am.. Resident #209 was originally admitted to the facility on 5/27/19 with the following diagnoses of, but not limited to anemia, coronary artery disease, high blood pressure, pneumonia, diabetes, arthritis and dementia. This resident was first admitted to a facility in which it was a "sister facility" but was transferred to present facility due to being able to meet the increased needs of this resident in a secure unit due to wandering tendencies and family request. This transfer of this resident occurred on 8/23/19. During the clinical record review by the surveyor on 9/11/and 9/12/19, the following documentation was noted on the Admission/Readmission Evaluation, which was completed on 8/23/19:	F 610	F610 Resident #209's continues to reside in the facility. The incident has been investigated and reported per regulations A review was conducted of the grievance log, and facility wide interviews were conducted with interviewable residents. Residents that are non-interviewable on the secure unit had a skin assessment completed and there were not any reportable issues identified. The Administrator/Designee provided staff training on abuse and reporting requirements. The Administrator/Designee will review resident council meeting minutes monthly for any potential reportable concerns, five random residents will be interviewed to ensure there are no reportable concerns identified weekly for three months. The grievance log will be reviewed weekly to ensure there are not any reportable concerns for three months. . The Administrator/Designee will submit the findings from the reviews to the QAPI Committee for three months for evaluation and any further recommendations. The Administrator/Designee	

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F 610	Continued From page 9 o" ...During the last 90 days resident had No Falls ... o The resident's cognitive status changed in the last 90 days was answered as No ... o Moderately impaired limited vision, but can identify objects ... o Confined to a chair ... o Balance not steady, only able to stabilize with physical assistance ... o 3 or more medications taken currently or within the last 7 days ... o Memory loss ..." o Resident #209 was also marked as requiring 1 person assist with ambulation, bed mobility, bathing, dressing, eating, toileting, and transfers. The surveyor reviewed the resident's clinical record on 9/11/19 and 9/12/19. During this review, the surveyor noted the following documentation dated and timed for 8/27/19 at 10:57 am which read, "While attempting to get resident dressed and cleaned up for the day, resident started yelling before anyone even touched this resident. No, your not going to beat me up and put more bruises on me! Do not touch me, you guys are mean to me! The resident was left alone for now to rest." The surveyor reviewed the nursing notes after this incident and there was no further documentation on the allegation of abuse. On 9/11/19 at approximately 4:45 pm, the surveyor asked the administrative team in the end of the day conference if they had any FRI's (Facility Reported Incidents) on Resident #209 for this date. The director of nursing and the regional nurse consultant both stated they were not aware of any FRI's that had been completed concerning	F 610	Date corrected: 10/10/2019	

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F 610	Continued From page 10	F 610		

this resident. Both stated they would look into this and provide the surveyor with any information that they find.

On 9/12/19 at 9:15 am, the regional nurse consultant, director of nursing (DON) and administrator in training (AIT) were present with the surveyor in the conference room. The regional nurse consultant stated, "I was wondering why you asked us for a FRI on this resident yesterday because all that we were aware of was 2 falls that occurred on 8/26 and 8/27/19. Both the DON and I worked late and read the nurses' notes and that was when we found the allegation of abuse that was documented by the nurse of 8/27/19 at 10:57 am." Both the regional nurse consultant and the DON stated they were not aware of this allegation until they were reviewing the notes last night (9/11/19). The regional nurse consultant stated, "After finding this out, we immediately faxed in a FRI to your office and notified the appropriate agencies of this allegation." The administrator in training stated that after these measures were taken, the staff was educated on reporting of any allegations of abuse immediately to their supervisor and then follow the chain of command so any allegations that are reported and investigations could be started within 2 hours of being told of an allegation. "We have been doing this as staff was clocking into work last night and following through until all staff are in-serviced on this." The surveyor asked if the nurse that wrote this note was working today. The DON stated, "No, she is on vacation and not on the schedule." The surveyor asked for a copy of the facility's policy on reporting allegations of abuse or neglect. The surveyor also requested a copy of any in services that staff had received in the past

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F 610	Continued From page 11	F 610		

year on abuse and neglect of any resident in the facility.
The surveyor was provided with a copy of the facility's policy titled "Virginia Resident Abuse Policy" which read in part, " ...Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy ..."

The administrator in training provided the surveyor with a list of courses that the facility staff are required to have on an annual base. Included in these courses, were the courses on abuse and neglect, who and how to report this to if they ever receive a report of any of this. The surveyor reviewed the documentation on this list and noted there was a completion percentage of 99.12% of staff had completed these annual courses.

The unit manager for the Memory Care Unit was interviewed on 9/12/19 at approximately 1 pm in the conference room. The surveyor asked if she had received any allegations of abuse in which Resident #209 had reported to a nurse and then that nurse documented the statements in a nurses' note on 8/27/19 at 10:57 am. The unit manager stated, "No one reported this incident to me and I was not aware of it until the DON had shown me the nurses' notes this morning."

The surveyor notified the Administrator along with the rest of the administrative team of the above documented findings on 9/12/19 at 3:30 pm. The surveyor asked the administrator if he had been aware of the allegation of abuse that had been documented in the nurses' notes of Resident

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F 610	Continued From page 12 #209 on 8/27/19 at 10:57 am. The administrator replied, "No one knew of this allegation until my staff was reading over the notes last night and found it." No further information was provided to the surveyor prior to the exit conference on 9/12/19.	F 610		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview the facility staff failed to ensure that a resident received treatment and care by following physician's orders for one of 12 residents in the survey sample, Resident # 210. The findings included: The facility staff failed to follow physician's orders to obtain weights every 3 days for Resident # 210. Resident # 210 was a 49-year-old-female who was originally admitted to the facility on 2/5/12, and with a readmission date of 8/29/19. Diagnoses included but were not limited to, heart failure, hypertension, quadriplegia, and chronic	{F 684}	F684 Resident #210 continues to reside in the facility. Resident #210, weights were reviewed and discussed with Nurse practitioner. Physician orders were clarified. The Director of Nursing completed a 100% audit of all residents with orders to notify physician related to weights outside of parameters. The Director of Nursing/Designee provided the licensed nurses with education regarding changes of condition policy and documentation of any notification of physicians and/or nurse Practitioner. Director of Nursing/Designee will	10/10/19

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{F 684}	Continued From page 13 kidney disease. The clinical record for Resident # 210 was reviewed on 9/10/19 at 3:35 pm. The most recent MDS (minimum data set) assessment for Resident # 210 was a quarterly assessment with an ARD (assessment reference date) of 7/29/19. In Section B0100, the facility staff documented that Resident # 210 was comatose. The current plan of care for Resident # 210 was reviewed and revised on 9/2/19. The facility staff documented a focus area for Resident # 210 as, "Resident has the potential for fluid deficit r/t tube feeding." Interventions included but were not limited to, "Weigh as ordered." Resident # 210 had orders that included but were not limited to, "Weight resident 3x's (times) weekly, if weight gain >5lbs (greater than 5 pounds) notify MD every MON, Wed, Fri related to heart failure," which was initiated by the physician on 7/26/19. On 9/10/19 at 3:46 pm, the surveyor observed a weight recorded in Resident # 210's clinical record of 133.8 Lbs. that was documented on 8/21/19 at 11:37 am. The surveyor observed a weight of 147 Lbs. documented on 8/23/19 that was documented at 6:32 pm. The surveyor observed that a single line was drawn through the weight of 147 Lbs. that had been documented on 8/23/19 at 6:32 pm. The surveyor reviewed the entire clinical record for Resident # 210 and did not observe any other weights documented for Resident # 210 on 8/23/19. On 9/11/19 at 9:00 am, the surveyor informed the director of nursing that a weight for 8/23/19 could	{F 684}	complete five random weekly audits for residents with orders to notify physician related to weights outside parameters per physician orders for twelve weeks. The Director of Nursing/Designee will submit the results of the audits to the monthly QAPI Committee for three months for evaluation and any further recommendations. Director of Nursing and/or designee Date of Correction: 10/10/2019	

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{F 684}	Continued From page 14 not be located in the clinical record for Resident # 210. On 9/11/19 at 1:45 pm, the director of nursing informed the surveyor that she did not observe a weight in the clinical record for Resident # 210. The director of nursing stated that the nurse did contact the facility nurse practitioner regarding the weight of 147 lbs. that had been documented on 8/23/19 at 6:32 pm. The director of nursing stated that the nurse practitioner felt that the weight was not accurate and informed nursing to get another weight on Monday. The director of nursing stated, "We put in a note and re-educated." The surveyor asked the director of nursing if there was a note regarding the weight documented on 8/23/19 that had a line drawn through it in the clinical record prior to the surveyor bringing it to the facility's attention. The director of nursing stated, "No but there should have been." On 9/12/19 at 4:35pm, the administrator, administrator in training, the director of nursing, and regional director of clinical services were made aware of the findings as stated above. The administrative team was provided the opportunity to ask questions and provide additional information to dispute the deficient practice as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 9/12/19.	{F 684}		
{F 689} SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	{F 689}		10/10/19

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{F 689}	Continued From page 15 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident representative interview, facility document review and clinical record review, the facility staff failed to ensure a safe and hazard free environment for 1 of 12 residents in the survey sample (Resident #209). The findings included: The facility staff failed to ensure a safe and hazard free environment in regards to Resident # 209's documented falls on 8/26 and 8/27/19 describing injuries to left forehead and obtained-laceration to fore head with moderate amount of blood, swelling, and redness. Resident #209 was originally admitted to the facility on 5/27/19 with the following diagnoses of, but not limited to anemia, coronary artery disease, high blood pressure, pneumonia, diabetes, arthritis and dementia. This resident was first admitted to a facility in which it was a "sister facility" but was transferred to present facility due to being able to meet the increased needs of this resident in a secure unit due to wandering tendencies and family request. This transfer of this resident occurred on 8/23/19. During the clinical record review by the surveyor on 9/11/and 9/12/19, the following documentation was noted on the Admission/Readmission Evaluation, which was completed on 8/23/19:	{F 689}	F689 Resident #209 continues to reside in the facility. Resident #209's falls were reviewed and care plan has been reviewed and updated with individualized interventions. A retrospective review of the past 30 day's falls/incidents was conducted. Care plan were reviewed, updated and revised as needed. Director of Nursing/Designee provided the Licensed staff, Social Worker, Dietician, Activities Director, Therapy with education on individualize approaches for resident care plans The Director of Nursing/Designee will conduct weekly audits to validate fall interventions are individualized for three months. The Director of Nursing/Designee will submit the findings from the audits to the monthly QAPI Committee meeting for three months for evaluation and any further recommendations. Director of Nursing and/or designee Date of Correction: 10/10/2019	

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{F 689}	Continued From page 16 " " ...During the last 90 days resident had No Falls ... " The resident's cognitive status changed in the last 90 days was answered as No ... " Moderately impaired limited vision, but can identify objects ... " Confined to a chair ... " Balance not steady, only able to stabilize with physical assistance ... " 3 or more medications taken currently or within the last 7 days ... " Memory loss ..." " Resident #209 was also marked as requiring 1 person assist with ambulation, bed mobility, bathing, dressing, eating, toileting, and transfers. The resident was also marked for evaluations for physical, speech and occupational therapies, which was documented on the above Admission/Readmission Evaluation that was completed on 8/23/19. The resident had been evaluated by occupational therapy (OT) on 8/26/19 and the recommendation was made for the resident to receive care of 2 to 5 times a week for 12 weeks. The long term goals set for this resident read in part, " ...Patient will complete all functional transfers with SBA (stand by assistance) in order to maximize her overall independence and to decrease the burden of care ..." The reason for therapy was documented as " ...Patient requires skilled OT services to maximize (I) (independence) w/ADL's (with activities of daily living), assess and modify environmental barriers, increase safety awareness, facilitate dynamic standing balance, increased functional activity tolerance, facilitate sitting tolerance and postural control and provision of modalities and strengthening ..."	{F 689}		

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{F 689}	Continued From page 17	{F 689}		

Physical therapy (PT) performed an evaluation of the resident on 8/25/19. The goals for PT read in part, " ...Patient will be able to ambulate rolling walker using proper technique and safety in order to decrease falls ..." The recommended frequency of PT visits were 2 to 5 times a week for a total of 12 weeks.

Speech therapy (ST) evaluated Resident #209 and recommended the frequency of visits for 2 to 5 times a week for 12 weeks. One of the documented goals for this resident read in part, " ...Patient will demonstrate use of her call button to request assistance with ambulation (or other needs) with 50% success given mod (moderate) instruction ..."

The care plan was reviewed by the surveyor and the following interventions that were noted in regards to Resident #209 being at risk for falls on admission of 8/23/19:
" ..."Anti rollbacks on w/c (wheelchair) ...
" Call bell within reach
" Keep room and hallways clear of clutter
" PT/OT screens prn (as needed) ..."

The physician's progress note dated for 8/26/19, the surveyor also reviewed Admission to Facility on 9/10/19 through 9/12/19. This note read in part, " ...Patient admitted to memory care unit here due to moderately severe dementia with psychosis. Patient's mobility is via (by) wheelchair ..."

On 8/26/19 at 6:55 am, the following documentation was noted, " ...Resident found sitting in floor with large contusion, left forehead bleeding. Stated she was trying to pull her diaper and pants up and fell forward hitting her head on

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the bathroom floor ...No other injury ...Immediate intervention: Head to toe assessment completed. Pressure applied to small abrasion on left forehead until bleeding stopped then pressure dressing applied, ...Sent to ER (emergency room) ...Resident knows staff names/faces. Resident is disoriented. Resident is cooperative ..."

The following intervention was noted to have been added to the care plan under the focus of "At risk for falls ..." on 8/26/19 after the resident sustained a fall with injury to left forehead:

" " ...Instruct resident to ask staff for assistance when going to bathroom ..."
There was another nursing note dated and timed for 8/27/19 at 4:30 am. This note read in part, " ...Resident found at this time lying in the floor at the bottom of bed in a pool of blood with decreased LOC (level of consciousness) Resident fell and hit her head on the footboard of the bed returning from the rest room. Injuries obtained-laceration to fore head with moderate amount of blood, swelling, and redness. _____ (name of provider) called and notified of residents condition at 0448 (4:48 am). Resident sent to ER for evaluation ..."

Staff reviewed the care plan after the second fall that occurred on 8/27/19 with the following addition made to the focus of "At risk for Falls":
" " ...Offer toileting frequently ..."

On 8/27/19 at 9:35 am, the following documentation was noted in the nursing notes:

"Resident experienced falls x's 2 since admission. Resident educated and oriented to CB (call bell) and to request assistance.

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{F 689}	Continued From page 19	{F 689}		

Resident can voice understanding and return demonstration, however resident does have a diagnosis of dementia ..."
The survey team that consisted of 2 surveyors went to Resident #209's room to interview the resident. The resident was lying in bed with eyes open and was able to verbalize how she was doing on this date. A surveyor asked the resident if she knew how to ask for assistance if she was needing to get out of bed or to go to the bathroom. The resident paused for a moment and then stated, "I'll just show you." The resident began to sit up in the bed, and was going to stand alone with no assistance. The surveyors asked the resident not to stand up without assistance. The surveyor asked the resident if she knew how to call for assistance when needing to get up. The resident looked confused at the surveyors and began to look around the covers of the bed. The surveyor picked up the call bell and asked the resident if she knew what this was used for. The resident stated, "No not really." LPN #1 came into the resident's room after the surveyor pushed the call bell to activate it. The surveyor explained to the resident that she was to push this little red button when she was needing or wanting to get up and the staff would came and help her so she wouldn't fall and hurt herself. The resident stated, "Oh."

On 9/11/19 at approximately 3:30 pm, the survey team interviewed the unit manager for the Memory Care Unit in the conference room. The unit manager stated she was familiar with Resident #209 and of the falls that had occurred on 8/26/19 and 8/27/19. The unit manager was asked what interventions were in place for this resident when she was admitted 8/23/19. The unit manager stated, "We would educate the

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{F 689}	Continued From page 20	{F 689}		

resident on using the call bell when needing to go to the bathroom and keep the room and hallway clear with no clutter that the resident could fall or trip over." The surveyor asked by knowing the history of this resident having dementia was the education provided to the resident on the use of the call bell a resident focused intervention that was appropriate for this resident. The unit manager stated, "No its not. There are times she would understand that but she wouldn't always remember to do that."

On 9/12/19 at 9:00 am, the surveyor met with administrator in training (AIT), director of nursing (DON) and regional nurse to discuss the events that led up to the resident having falls on 8/26/19 and again on 8/27/19. The regional nurse provided the surveyor with a time line outlining the falls on 8/26/19 and 8/27/19 and when each of the new interventions were put in place after each of the falls. The time line that was provided outlined the above documented findings in the documentation in the nursing notes as well as the additional interventions that was added to the care plan. The DON stated, "We put all of these interventions in place at time of admission and then added additional interventions after each fall as you have seen on the care plan." The surveyor asked the DON if the intervention of educationing the resident to use the call bell when needing assistance was appropriate for a resident that had a diagnosis of dementia and was residing in the Memory Care Unit. The DON replied, "At times the resident could remember how to use the call bell but with her dementia she probably wouldn't remember that for very long."

The daughter of Resident #209 called the facility and requested to speak to the surveyor. This

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{F 689}	Continued From page 21 was on 9/12/19 at 9:45 am. The daughter stated she was pleased with her mother's care at this facility. The surveyor asked if she had been present when the staff had explained the use of the call bell to her mother. The daughter stated, " I have. But they can tell her over and over what to do and as soon as they leave the room she would look at me and say What are they talking about." The surveyor notified the administrative team of the above documented findings on 9/12/19 at 1:30 pm in the conference room. The surveyor requested and received copy of the facility's policy titled "Fall Management Program". In this policy it read in part, " ...To establish a fall management program 3 main elements are needed: Review of the resident's risk factors, Planned service plan and interventions that are resident specific, Continuous review of effectiveness of the service plan and interventions ..." No further information was provided to the surveyor prior to the exit conference on 9/12/19.	{F 689}		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by	F 693		10/10/19

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F 693	Continued From page 22 enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to provide appropriate care and services in regards to gastrostomy tube for 1 of 4 residents observed during a medication pass and pour observation, Resident # S2. The findings included The facility staff failed to appropriately check gastrostomy tube placement and residual for Resident # S2. On 9/12/19 at 8:47 am, the surveyor conducted a medication pass and pour observation with LPN # 1 (licensed practical nurse). The surveyor observed LPN # 1 as she applied a syringe to Resident # S2's gastrostomy tube and pulled the syringe plunger back. The surveyor observed a small amount of dark yellow liquid residual return into the syringe. The surveyor observed LPN # 1 as she pushed down on the plunger and returned residual the contents to Resident # S2. The surveyor observed LPN # 2 as she removed the plunger from Resident # S2's peg tube, pulled	F 693	F693 Resident #S2 continues to reside at the facility. The Director of Nurse provided the nurses with education related to checking proper placement technique. Director of Nursing/Designee completed a 100% audit of resident's with feeding tubes to ensure accurate and current physician's order. Director of Nursing/Designee provided education and competency training for licensed nurses related to proper technique for checking placement of a feeding tube. The Director of Nursing/Designee will complete three technique observations weekly related to the proper technique for checking placement of a feeding tube for three months. The Director of Nursing/Designee will submit the findings to the Monthly QAPI Committee Meeting for evaluation and any further recommendations for three months.	

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F 693	Continued From page 23 back on the plunger, and replaced the plunger into Resident # S2's gastrostomy tube. The surveyor then observed LPN # 1 place her stethoscope on Resident # S2's stomach and inserted air into Resident # S2's gastrostomy tube to check placement. On 9/12/19 at 10:03 am, the surveyor interviewed LPN # 1. The surveyor asked LPN # 1 why she checked the residual prior to checking placement when preparing to administer medications via gastrostomy tube to Resident # S2. LPN # 1 stated, "That's the way I was taught to do it a long time ago." The facility policy relating to "Medication Administered through an Enteral Tube" contained documentation that included but was not limited to, ..."Procedure Facility should check the placement of the naso-gastric or gastrostomy tube in accordance with facility policy. Checking gastric residual volume." ... On 9/12/19 at 4:35pm, the administrator, administrator in training, the director of nursing, and regional director of clinical services were made aware of the findings as stated above. The administrative team was provided the opportunity to ask questions and provide additional information. No further information regarding this issue was presented to the survey team prior to the exit conference on 9/12/19.	F 693	Director of Nursing/Designee Date corrected: 10/10/2019	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		10/10/19

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F 760	Continued From page 24 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview, and facility document review, the facility staff failed to ensure that 1 of 4 Residents observed during a medication pass and pour observation were free of significant medication errors, Resident # S1. The findings included: The facility staff failed to appropriately administer Lantus via insulin pen to Resident # S1. Resident # S1 was a 76-year-old- female who was originally admitted to the facility on 11/10/15, with a readmission date of 6/17/19. Diagnoses included but were not limited to; type 2 diabetes mellitus, obesity, hypertension, and anemia. Resident # S1 had orders that included but were not limited to, "Lantus Solution 100 unit/ML (milliliter) Inject 20 unit subcutaneously two times a day for dm (diabetes mellitus)." On 9/12/19 at 9:29 am, the surveyor observed LPN # 2 (licensed practical nurse) administer medications to Resident # S1. The surveyor observed LPN # 2 as she administered 20 units of Lantus via insulin pen to Resident # S1 on the left side of her abdomen. The surveyor observed LPN # 2 as she pressed the injection button on the insulin pen, and immediately removed the insulin pen from Resident # S1's left abdomen. The surveyor observed that LPN # 2 did not hold	F 760	F760 Resident # S1 continues to reside in the facility. The Director of Nursing provided the Licensed Nurse with educated related to proper insulin administration. The Director of Nursing/Designee completed a 100% audit of resident's with physician orders for insulin to ensure accurate and current. Director of Nursing/Designee were provided education for the licensed nurses related to proper insulin administration technique. Director of Nursing/Designee will observe three nurses weekly to ensure proper insulin administration technique for three months. The Director of Nursing/Designee will submit the results of observations to the monthly QAPI Committee Meeting for three months for evaluation and any further recommendations. Director of Nursing and/or designee. Date corrected: 10/10/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495134	A. BUILDING _____ B. WING _____	R 09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 25	F 760		

the Lantus pen in place for 10 seconds following the injection to ensure that full dose of Lantus had been delivered.

On 9/12/19 at 4:09 pm, the surveyor interviewed LPN # 2. The surveyor asked LPN # 2 why she did not pinch the skin on Resident # S1's abdomen when she administered the 20 units of Lantus with the insulin pen. LPN # 2 stated, "She usually pinches it herself." The surveyor informed LPN # 2 that Resident # S1 did not pinch her skin during the administration of the Lantus. The surveyor asked LPN #2 why she did not hold the insulin pen in place after pressing the injection button to ensure that Resident # S1 had received all of the medication. LPN #2 stated, "I thought I did."

On 9/12/19 at 4:30 pm, the director of nursing provided the surveyor with the facility standard of practice for "Lantus Solostar (insulin glargine injection)." The facility standard of practice contained documentation that included but was not limited to,
..."Step 5. Inject the dose
A. Use the injection method as instructed by your health care professional.
B. Insert the needle into the skin
C. Deliver the dose by pressing the injection button in all the way. The number in the window will return to "0" as you inject.
D. Keep the injection button pressed all the way in. Slowly count to 10 before you withdraw the needle from the skin. This ensures that the full dose will be delivered."" ...

On 9/12/19 at 4:35pm, the administrator, administrator in training, the director of nursing, and regional director of clinical services were

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F 760	Continued From page 26 made aware of the findings as stated above. The administrative team was provided the opportunity to ask questions and provide additional information to dispute the deficient practice as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 9/12/19.	F 760		