STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495126	A. BUILDING _____ B. WING _____	08/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADDELL NURSING AND REHAB CENTER	202 PAINTER ST GALAX, VA 24333

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 08/06/19 through 08/09/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. The census in this 130 certified bed facility was 126 at the time of the survey. The final survey sample consisted of 25 current resident reviews and two (2) closed record reviews.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/6/19 through 8/9/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety survey/report will follow. The census in this 130 certified bed facility was 126 at the time of the survey. The survey sample consisted of 25 current Resident reviews and 2 closed record reviews .	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		9/18/19

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

Electronically Signed | 09/09/2019

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F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to provide a dignified existance by ensuring that privacy was maintained for residents during a group meeting. The findings included: During the group meeting, a facility staff entered the meeting, disturbing the group meeting, and	F 550	The Certified Nursing Assistant #1 was counseled on August 7, 2019 in regards to respecting resident rights and the privacy of resident council meetings. #1 was instructed to pay attention to any postings on the door to the dining room to determine whether she may enter. Current staff was educated by the Social	

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F 550	Continued From page 2 proceeded to heat their food in the microwave. On 08/07/19 at 11:00 a.m., a group meeting wasas held with nine alert and orientated Residents of the facility. This meeting was held in the resident dining area. Prior to leaving the room, the activity staff shut the door. The staff had previously posted a notice on the entrance door that would alert anyone who wished to enter that a group meeting was being conducted. At 11:09 a.m., CNA (certified nursing assistant) #1 entered the group meeting, placed her food into the microwave, and proceeded to heat her food. After heating her food, CNA #1 left the dining area. At the conclusion of this meeting, the surveyor checked the outside door of the meeting room to ensure the sign was still posted. This sign was still in place. On 08/07/19 at approximately 4:08 p.m., the administrator, director of nursing, regional vice president of operations, and regional director of clinical services were notified of the issue regarding CNA #1 disturbing the group meeting. On 08/08/19 at 7:44 a.m., CNA #1 stated she saw the sign on the outside of the door for group but did not realize it meant she should not enter. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 550	Service Director concerning resident rights. New staff members will be educated on resident rights and resident council meeting protocols Resident council meetings dates and protocols are reviewed to assure that the proper notice will be provided to staff prior to the meeting dates. The Activity Director will monitor for compliance monthly during resident meetings for three months. Deficient practices will be reported to the Administrator for further action. Quality Assurance and Performance Improvement Committee will review weekly until deficient practice is cleared.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		9/18/19

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F 578	Continued From page 3	F 578		

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

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

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the

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F 578	Continued From page 4 appropriate time. This REQUIREMENT is not met as evidenced by: Based on interviews, clinical record review, and facility document review, it was determined the facility staff failed to correctly address residents' advance directives for three (3) of 25 sampled residents (Resident #57, Resident #34, and Resident #123). The findings included: 1. The facility staff failed to correctly address Resident #57's advance directive decisions. Resident #57 was admitted on 3/15/18. Resident #57's diagnoses included, but were not limited to: high blood pressure, urinary tract infection, and sepsis. Resident #57's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/22/19 assessed the resident with a BIMS (brief interview for mental status) score of 15 out of 15; this assessment also documented the resident as being able to express ideas and wants and as being able to make himself/herself understood. During the review of Resident #57's clinical record on 8/6/19 at approximately 4:00 p.m., a document titled "POLICY ON CPR (CARDIOPULMONARY RESUSCITATION)" was noted. This document was completed on 3/15/18; it was signed by Resident #57's responsible party. This document had the following statement selected: "I do not wish CPR be performed."	F 578	The code status for resident #57 was changed on August 6, 2019 to accurately reflect the wishes of the resident. The Social Service Director and Social Service Assistant conducted a 100% audit of all current residents to assure that code status was accurate. Clinical and Social Service staff were educated by the Administrator and the Regional Clinical Nurse Consultant on completing the appropriate code status forms. Social Service Staff will complete weekly audits with resident care plan review and all new admissions are reviewed to assure appropriate code status. Social Service Director will monitor weekly in coordination with care plan updates to assure compliance and report any deficient practice to the Administrator for further action. Quality Assurance and Performance Improvement Committee will review weekly until deficient practice is cleared.	

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F 578	Continued From page 5	F 578		

On 8/6/19 at 04:13 p.m., Licensed Practical Nurse (LPN) #16 was interviewed about Resident #57's code status; LPN #16 reported the resident was a full code. LPN #16 showed the surveyor a 'unit report form' which had a heart-shaped symbol beside Resident #57's name. LPN #16 stated the heart-shaped symbol indicated the patient was a full code. On the afternoon of 8/6/19, it was also noted that Resident #57's clinical record included a care plan which included the "Focus" of "Resident/Responsible party has chosen Full Code".

On 8/7/19 at 9:25 a.m., LPN #14 provided the surveyor with the following documents:
- a revised care plan for Resident #57, dated 8/6/19, indicating the patient was now DNR (do not resuscitate),
- a provider order for Resident #57, dated 8/6/19 and timed 4:45 p.m., indicating the patient was DNR, and
- a Durable Do Not Resuscitate (DDNR) Order form completed for Resident #57 on 8/6/19.

The issue of Resident #57 being a full code when documentation in the resident's clinical record indicated the resident was not to receive CPR was discussed during a survey team meeting with the facility's administrative team on 8/7/19 at 4:25 p.m.; the facility's administrative team at this meeting included the Administrator, the Director of Nursing (DON), the Regional Director of Clinical Services, and the Regional Vice-President of Operations.

On 8/8/19 at 1:30 p.m., LPN #12 provided the survey team with a policy titled "Code Status Audit Policy" (this policy had an effective date of December 2015 and a reviewed date of April

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F 578	Continued From page 6	F 578		

2019). This policy included the following statement: "The Facility will ensure resident's [sic] code status is accurate and current throughout the residents stay and the clinical record represent the accurate code status."
2. For Resident #123 the facility staff failed to ensure the DDNR (durable do not resuscitate) form was complete.

Resident #123 was admitted to the facility on 07/19/19. Diagnoses included but not limited to cancer, hypertension, pneumonia, diabetes mellitus, hyperlipidemia, hypothyroidism, anxiety, depression, and respiratory failure.

The admission MDS (minimum data set) with an ARD (assessment reference date) of 07/26/19 assigned the Resident a BIMS (brief interview for mental status) score of 13 out of 15 in section C, cognitive patterns.

The advance directives section of the Resident's clinical record was reviewed on 08/06/19. It contained a Virginia Department of Health DDNR form, which read as follows:

"I further certify (must check 1 or 2):
[] 1. The Patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)
[] 2. The Patient is INCAPABLE of making an informed decision about provided, withholding, or withdrawing a specific medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision , or to make a rational evaluation of the risks and benefits of alternatives

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F 578	Continued From page 7	F 578		

to that decision.
If you checked 2 above, check A, B, or C below:
[] A. While capable of making an informed decision, the Patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.
[] B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.)
[] C. The Patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf is required)"

Sections I and II of the DDNR form had not been checked as directed.

Surveyor spoke with the ADON (assistant director of nursing) on 08/07/19 at approximately 2:45 PM regarding the incomplete DDNR form. ADON stated that the form should have been completed.

The concern of the incomplete DDNR form was discussed with the administrative team (administrator, director of nourishing, regional nurse consultant, and regional vice-president of operations) on 08/07/19 at approximately 4:20 PM.

No further information was provided prior to exit.
3. For Resident #34, the facility staff failed to complete a DDNR (durable do not resuscitate).

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F 578	Continued From page 8	F 578		

All the boxes on this form had been left blank (unchecked).

The clinical record review revealed that Resident #34 had been admitted to the facility 02/14/19. Diagnoses included, but were not limited to, hypertension, asphyxia, chronic kidney disease, and other diseases of larynx.

Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/21/19 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section O (special treatments/procedures/programs) had been coded to indicate the Resident was receiving hospice services.

The EHR (electronic health record) was reviewed on 08/06/19.

The EHR included a DDNR order form dated 02/15/19. The physician and Resident #34 had signed this DDNR

This DDNR read in part.
Under section 1 "I further certify [must check 1 or 2]:
1. The patient is CAPABLE of making an informed decision...
2. The patient is INCAPABLE of making an informed decision..."
Neither box had been checked.

Section 2 read, "If you checked 2 above, check A, B, or C below..." All three boxes had been left blank.

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F 578	Continued From page 9 On 08/06/19 at 3:45 p.m., this DDNR was shared with the DON (director of nursing). The DON acknowledged the DDNR was incomplete. On 08/08/19 at approximately 4:04 p.m., the administrator, DON, regional vice president of operations, and regional director of clinical services were notified of the issue regarding Resident #34's DDNR being incomplete. Prior to the exit conference on 08/09/19, the facility provided the surveyor with an updated copy of the Residents DDNR dated 08/06/19. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 578		
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 paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, employee record review, facility document review, the facility staff failed to implement their policy/procedure in regards to new hires and criminal background	F 607	The criminal background checks were obtained for new hires #6, #13, and #17 prior to the survey. The facility Staffing Coordinator is responsible for assuring	9/18/19

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F 607	Continued From page 10 checks for 3 of 25 new hires (New hire #6, #13, and #17). The findings included: The facility staff failed to obtain criminal background checks upon hire per their facility policy/procedure. Facility policy titled "Employee Background Screening" read in part, "...Each facility shall conduct a criminal background check of all employees, as required by law, upon hire..." The surveyor reviewed 25 new hire employee record on 08/07 and 08/08/19. Employee #6 was an LPN (licensed practical nurse). Documented DOH (date of hire) 10/08/18 criminal background check completed 12/20/18. Employee #13 was a cook. Documented DOH (08/30/18) criminal background check completed 10/09/18. Employee #17 was an activity staff. Documented DOH (10/26/18) criminal background check completed 12/19/18. On 08/08/19 at 10:00 a.m. human resource employee #1 was asked if they had any further information regarding background checks for these three employees. On 08/08/19 at 1:21 p.m., the surveyor reviewed the hire dates and criminal background dates with human resource employee #1. After this review, this employee verbalized to the surveyor that she had not completed the paperwork for employees	F 607	that all criminal background checks are received within the time frame dictated by facility policy. The Staffing Coordinator completed a 100% audit of all current employee files to assure compliance with facility compliance The Regional Director of Clinical Services educated the Administrator and the Staffing Coordinator on the facility policy. The Administrator will review the orientation files of new hires for three months to assure compliance with facility policy. Quality Assurance and Performance Improvement Committee will review weekly until deficient practice is cleared.	

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F 607	Continued From page 11 #6 and #17. For employee #13 human resource employee #1 stated they must have missed it. On 08/08/19 at approximately 4:04 p.m., the administrator, DON, regional vice president of operations, and regional director of clinical services were notified of the issue regarding employee records. On 08/09/18 at 8:32 a.m., during the QA (quality assurance) task with the administrator, the administrator verbalized to the surveyor that by the end of May they had realized they had placed too much on one person and made some internal changes in regards to job duties. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 607		
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 by: Based on staff interview and clinical record review, the facility staff failed to accurately complete MDS (minimum data set) assessments for 2 of 27 residents, Residents #34 and #92. The findings included: 1. For Resident #34, the facility staff failed to completed sections C (cognitive patterns) and D (mood) of the resident's quarterly MDS assessment with an ARD (assessment reference	F 641	The assessments for residents #34 and #92 were updated on August 9, 2019 to accurately reflect cognitive status, mood and behaviors. The MDS Coordinator completed a 100% audit of MDS to assure completion of all sections. The Regional Director of Clinical Service educated the Administrator, the Social	9/18/19

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F 641	Continued From page 12 date) of 05/24/19. The clinical record review revealed that Resident #34 had been admitted to the facility 02/14/19. Diagnoses included, but were not limited to, hypertension, asphyxia, chronic kidney disease, and other diseases of larynx. Section C (cognitive patterns) of the resident's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/21/19 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The EHR (electronic health record) was reviewed on 08/06/19. During a review of the resident's MDS assessment with an ARD of 05/24/19, it was noted that sections C and D had been marked with dashes (-). On 08/06/19 at 4:05 p.m., the surveyor reviewed the MDS with the DON (director of nursing). On 08/07/19 at 9:07 a.m., the surveyor interviewed the SW (social worker), the SW verbalized to the surveyor that she really did not know the reason why it had dashes. "...typically we get them all done timely..." This SW stated she was responsible for sections C, D, E, and Q. The MDS coordinator that had signed this MDS as being complete was no longer employed at the facility. On 08/08/19 at approximately 4:04 p.m., the administrator, DON, regional vice president of	F 641	Service Director, and Social Service Assistant on the completion of section C and D of the MDS. The MDS Coordinator will review MDS prior to submission to assure all sections are complete. Deficient practice will be reported to the Administrator. Quality Assurance and Performance Improvement Committee will review weekly until deficient practice is cleared.	

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operations, and regional director of clinical services were notified of the issue regarding Resident #34's MDS assessment being inaccurate.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. For Resident #92, the facility staff failed to complete sections C (cognitive patterns) and D (mood) of 2 MDS (minimum data set) assessments.

The clinical record review revealed that Resident #92 had been admitted to the facility 08/21/17. Diagnoses included, but were not limited to, difficulty in walking, type 2 diabetes, dysphagia, essential hypertension, and dysphagia.

Section C of the resident's quarterly MDS assessment with an ARD (assessment reference date) of 01/03/19 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.

The resident's EHR (electronic health record) was reviewed on 08/07/19 after a concern brought up in the group meeting.

This review revealed that the facility staff had marked sections C and D of the resident's quarterly MDS assessment with an ARD (assessment reference date) of 04/05/19 and the resident's annual MDS assessment with an ARD of 07/06/19 with dashes (-).

For the MDS with an ARD of 04/05/19 LPN #2 had signed the MDS as being responsible for

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F 641	Continued From page 14 sections C and D. The RN (registered nurse) that had signed the assessment as complete was no longer employed at the facility. On 08/07/19 at 3:10 p.m., LPN (licensed practical nurse) #2 verbalized to the surveyor that she had dashed the sections, as she had no information from social services. LPN #2 then added we have asked and emailed. For the MDS with an ARD of 07/06/19 the RN that had signed for sections C and D to be completed and for the assessment to be complete was no longer employed at the facility. On 08/08/19 at approximately 4:04 p.m., the administrator, DON, regional vice president of operations, and regional director of clinical services were notified of the issue regarding Resident #92's MDS assessments being incomplete. No further information regarding this issue was provided to the survey team prior to the exit conference.	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	F 656		9/18/19

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F 656	Continued From page 15 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to implement the resident's comprehensive care plan in regards to a foley catheter for 1 of 27 residents, Resident #66. The findings included:	F 656	The comprehensive care plan for resident #66 was immediately updated to reflect the resident□s need for a catheter anchor. The MDS coordinator completed a 100% audit of all care plans to assure that	

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F 656	Continued From page 16 The facility staff failed to implement the resident's comprehensive care plan in regards to anchoring the resident's foley catheter. The clinical record review revealed that Resident #66 had been admitted to the facility 02/28/17. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, chronic kidney disease, type 2 diabetes, schizoaffective disorder, Alzheimer's disease, obstructive and reflux uropathy, benign prostatic hyperplasia, and bipolar disorder. Section C (cognitive patterns) of the resident's significant change in status MDS (minimum data set) assessment included a BIMS (brief interview for mental status) summary score of 13 out of a possible 15 points. Section H (bladder and bowel) was coded to indicate the resident had a catheter. The resident's EHR (electronic health record) included the following physician's orders- Anchor catheter tubing and check placement every shift. Foley catheter for obstructive uropathy. The resident's comprehensive care plan included the focus area risk for complication in urinary system related to foley catheter use. Interventions included, but were not limited to, "anchor catheter tubing and check placement every shift." On 08/08/19 at 7:40 a.m., the surveyor and CNA (certified nursing assistant) #5 checked the resident's foley catheter. This foley catheter was not anchored. On 08/08/19 at 2:26 p.m., the surveyor and LPN	F 656	treatment orders were accurately reflected in the plan. The Regional Director of Clinical Services educated Unit Managers and MDS staff on reviewing treatment orders to assure that they are accurately reflected in the care plan. MDS staff will audit care plans weekly to assure treatment orders are current and that care plans are updated timely Quality Assurance and Performance Improvement Committee will review weekly until deficient practice is cleared.	

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F 656	Continued From page 17 (licensed practical nurse) #2 again checked this foley catheter. The foley catheter was now anchored. LPN #2 verbalized to the surveyor that one of the CNA's had put the strap in place. On 08/08/19 at 3:35 p.m., CNA #4 stated she thought CNA #5 had put the strap in place. Attempts to interview this resident were unsuccessful. On 08/08/19 at approximately 4:04 p.m., the administrator, DON, regional vice president of operations, and regional director of clinical services were notified of the issue regarding Resident #66's foley catheter not being anchored. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		9/18/19

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F 657	Continued From page 18 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 and clinical record review the facility staff failed to review and revise a comprehensive care plan for 1 of 27 residents, Resident #40. The findings included: For Resident # 40 the facility staff failed to revise a care plan for skin breakdown. Resident #40 was admitted to the facility on 10/03/18 and readmitted on 01/17/19. Diagnoses included but not limited to hypertension and Alzheimer's disease. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/31/19 assigned the resident a BIMS (brief interview for mental status) score of 12 out of 15 in section C, cognitive status. Surveyor observed Resident #40 on 08/07/19 at approximately 8:45. The resident did not have skin-sleeves on either arms or legs at this time.	F 657	The comprehensive care plan for resident #40 was immediately updated to accurately reflect the need for skin sleeves. The MDS coordinator completed a 100% audit of all care plans to assure that treatment orders were accurately reflected in the plan. The Regional Director of Clinical Services educated Unit Managers and MDS staff on reviewing treatment orders to assure that they are accurately reflected in the care plan. MDS staff will audit care plans weekly to assure treatment orders are current and that care plans are updated timely Quality Assurance and Performance Improvement Committee will review weekly until deficient practice is cleared.	

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Resident #40's clinical record was reviewed on 08/08/19. The physician's orders section of the clinical record contained a signed physician's order summary for the month of August 2019, which read in part "Keep vaseline over both legs and cover with skin sleeves on lower legs at all times. The physician's order summary also contained an entry which read in part, "Geri-sleeves to bilateral arms to maintain skin integrity every day shift to maintain skin integrity-start date 02/18/19, end date-03/29/19."

Resident #40's comprehensive care plan was reviewed and contained a care plan for "at risk for skin breakdown related to: decreased mobility, weakness, med use, wears geri-legs (skin sleeves) per Resident request." Interventions for this care plan included geri-legs and geri-sleeves to all extremities for protection of skin from bumping into objects".

Surveyor observed Resident #40 again on 08/08/19 at approximately 1:40. The resident did not have skin-sleeves on either arms or legs at this time. Surveyor observed a bandage to left elbow and two bandages to left lower leg.the

Surveyor spoke with LPN #2 on 08/08/19 at approximately 3:35 PM regarding Resident #40's comprehensive care plan. Surveyor asked LPN #2 if the intervention for geri-sleeves should be on the care plan, and LPN #2 stated that it should have been removed when the care plan was updated.

The concern of not reviewing/revising the resident's care plan was discussed with the administrative team (administrator, director of nursing, regional nurse consultant, and regional

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F 657	Continued From page 20 vice-president of operations) during a meeting on 08/08/19 at approximately 4:00 PM. No further information was provided prior to exit.	F 657		
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 observation, staff interview and clinical record review the facility staff failed to ensure that residents receive treatment and care by following physician's orders for 3 of 27 residents, Residents #25, #40 and #110. The findings included: 1. For Resident #25 the facility staff failed to follow physician's orders for the administration of insulin. Resident #25 was admitted to the facility on 01/23/18 and readmitted on 08/03/19. Diagnoses included but not limited to hypertension, obstructive uropathy, diabetes mellitus, dementia, Parkinson's disease, depression, acute kidney failure and gastroesophageal reflux disease. The most recent quarterly MDS (minimum data	F 684	The physician orders were reviewed for resident #25, #40, and #92 for accuracy of medications and treatments. Orders were updated to accurately reflect the care provided. The Director of Nursing and Unit Managers completed a 100% audit of all insulin orders to assure that they accurately reflect the treatment being provided. The DON and Unit Managers completed a 100% audit of all Geri-sleeve orders to assure that the treatment was being provided. Clinical staff were educated on following physician orders on both the medical administration record and the treatment administration record.	9/18/19

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F 684	Continued From page 21 set) with an ARD (assessment reference date) of 05/24/19 assigned the resident a BIMS (brief interview for mental status) score of 6 out 15 in section C, cognitive status. Resident #25's comprehensive care plan was reviewed and contained a care plan for "Resident is at risk for hypo/hyperglycemia episodes R/T (related to): IDDM (insulin dependent diabetes mellitus)." Interventions for this care plan include medication as ordered. Resident #25's clinical record was reviewed on 08/07/19. It contained a signed physician's order summary for the month of August 2019, which read in part "Humalog Kwickpen 3 ml 100.units/ml. Inject 10 units subcutaneously two times a day for DM (diabetes mellitus). Hold if BS (blood sugar) < (less than) 140." Resident #25's eMAR (electronic medication administration record) for the months of July and August 2019 were reviewed. The eMAR's contained an entry, which read in part, "Humalog Kwickpen 3 ml 100 units/1 ml Unit. Inject 10 unit subcutaneously two times a day for DM. Hold if BS <140." The blood sugar for 07/04/19 at 9:00 AM was recorded as 122, and the entry was signed as administered. The blood sugar for 07/09/19 at 9:00 AM was recorded as 126 and the entry was signed as administered. The blood sugar for 08/05/19 was recorded as 126 and the entry was signed as administered. The blood sugar for 08/07/19 was recorded as 128, and the entry was signed as administered. The surveyor spoke with RN #1 on 08/08/19 at approximately 3:35 PM regarding Resident #25's insulin. Surveyor asked RN #1 what a check and	F 684	Unit managers will conduct rounds 5 days a week to assure treatments are administered according to physician orders. Unit managers will conduct audits five days a week of insulin administration to assure that it is administered according to physician orders. Quality Assurance and Performance Improvement Committee will review weekly until deficient practice is cleared.	

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initials indicated on the eMAR, and she stated that it meant the medication was administered as ordered. Surveyor then asked RN #1 to look at Resident #25's eMAR for the dates indicated above. RN #1 stated that the resident's insulin should not have been administered on these dates.

The concern of not following the physician's orders for Resident #25 was discussed with the administrative staff (administrator, director of nursing, regional nurse consultant, and regional vice-president of operations) during a meeting on 08/08/19 at approximately 4:00 PM.

No further information was provided prior to exit.

2. For Resident #40 the facility staff failed to follow physician's orders for the use of geri-legs skin sleeves.

Resident #40 was admitted to the facility on 10/03/18 and readmitted on 01/17/19. Diagnoses included but not limited to hypertension and Alzheimer's disease.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/31/19 assigned the resident a BIMS (brief interview for mental status) score of 12 out of 15 in section C, cognitive status.

Surveyor observed Resident #40 on 08/07/19 at approximately 8:45. The resident did not have skin-sleeves on either arms or legs at this time.

Resident #40's clinical record was reviewed on 08/08/19. The physician's orders section of the

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clinical record contained a signed physician's order summary for the month of August 2019, which read in part "Keep vaseline over both legs and cover with skin sleeves on lower legs at all times. The physician's order summary also contained an entry which read in part, "Geri-sleeves to bilateral arms to maintain skin integrity every day shift to maintain skin integrity-start date 02/18/19, end date-03/29/19."

Resident #40's comprehensive care plan was reviewed and contained a care plan for "at risk for skin breakdown related to: decreased mobility, weakness, med use, wears geri-legs (skin sleeves) per Resident request." Interventions for this care plan included geri-legs and geri-sleeves to all extremities for protection of skin from bumping into objects".

Surveyor observed Resident #40 again on 08/08/19 at approximately 1:40. The resident did not have skin-sleeves on either arms or legs at this time. Surveyor observed a bandage to left elbow and two bandages to left lower leg.

Surveyor spoke with LPN #1 on 08/08/19 at approximately 1:50 PM. Surveyor asked LPN #1 if Resident #40 was supposed to be wearing skin sleeves on his legs and LPN #1 stated, "He has them for his arms but not his legs, he doesn't have an order for his legs yet. He is wearing them on his arms". Surveyor asked LPN #1 to pull Resident #40's physician's order summary. LPN #1 read the order summary, and stated "I guess he is supposed to be wearing them on his legs".

The concern of not following the physician's orders for geri-sleeves was discussed with the administrative staff (administrator, director of

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nursing, regional nurse consultant, and regional vice-president of operations) during a meeting on 08/08/19 at approximately 4:00 PM.

No further information was provided prior to exit.
3. For Resident #92, the facility staff failed to administer the residents 9:00 a.m. medication until the resident verbalized a concern to the surveyor during a group meeting and had awoken the resident at 1:00 a.m. to administer aspirin.

The clinical record review revealed that Resident #92 had been admitted to the facility 08/21/17. Diagnoses included, but were not limited to, difficulty in walking, type 2 diabetes, dysphagia, essential hypertension, and dysphagia.

Section C of the resident's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/03/19 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.

The resident's EHR (electronic health record) was reviewed on 08/07/19 after a concern brought up in the group meeting regarding not receiving her morning insulin and being awoken at 1:00 a.m. to be administered an aspirin.

On 08/07/19 at 11:21 a.m., Resident #92 verbalized to the surveyor that she had not received her morning insulin. Resident #92 stated the nursing staff had checked her BS (blood sugar) but she did not get her insulin. When asked if she felt okay, Resident #92 stated she did. Resident #92 also stated the facility nursing staff had awoken her at 1:00 a.m. to administer an aspirin.

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F 684	Continued From page 25	F 684		

The surveyor immediately spoke with the administrator and LPN (licensed practical nurse) #1. LPN #1 verbalized to the surveyor that the resident had not received her insulin as she had not been in her room and she was unable to find her. LPN #1 stated the resident's insulin was due to be administered at 10:00 a.m.

On 08/07/19 at 11:32 a.m., LPN #1 verbalized to the surveyor that she had not administered any of the resident's morning medications that the computer system was new to her, and she was just trying to figure it out. During this interview, LPN #6 verbalized to the surveyor that she had just administered the resident's medications.

A review of the resident's eMARs (electronic medication administration records) revealed that the resident was due to receive lasix 20 mg for edema, lisinopril 20 mg for hypertension, norvasc 10 mg for hypertension, therems tablet (multivitamin), 18 units of lantus insulin for diabetes, and metformin 500 mg for diabetes. LPN #1 had signed for all of these medications as if they had been administered. In regards to the resident's aspirin the resident's physicians orders revealed that the resident had a new order for aspirin 81 mg to be given in the morning for prophylaxis the order date was documented as 08/05/19 and the start date was documented as 08/06/19. A review of the resident's eMAR revealed that the facility nursing staff had placed a check mark beside the time of 12:00 a.m. on 08/07/19 indicating the aspirin had been administered. The facility nursing staff had also placed a check mark beside the timeframe of 8:00 a.m. on 08/06/19 indicating the aspirin had been administered.

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F 684	Continued From page 26	F 684		

There was no medication scheduled for 10:00 a.m. as LPN #1 stated.

08/07/19 at 2:52 p.m., LPN #1, who was an agency nurse, verbalized to the surveyor that it was her third day in the building and her first day on that unit. When asked if she had received any orientation LPN #1 stated "A little." On the first day, they kind of showed me around the facility, ins and outs of the computer. If I have an issue, I just grab whom I see and they direct me to whomever. LPN #1 stated she had been a nurse 12 years and that the resident's BS was obtained on 3rd shift and when she was completing the medication pass the Resident was there and after she had set up the Residents medications, she was gone. LPN #1 stated the Resident was in therapy and therapy stated she would be up there for 45 minutes. LPN #1 stated she called back to therapy and therapy said she was down here. I could not find her. LPN #1 stated she was still familiarizing herself with the system. When asked why she had signed as if the medication had been administered LPN #1 stated you can check yes, you can hit lock, or save and apparently I hit the save button instead of the lock button. LPN #1 stated she had relieved an agency nurse when she took report and there was not a whole lot the previous nurse could tell me about the unit.

On 08/07/19 at approximately 4:08 p.m., the administrator, DON (director of nursing), regional vice president of operations, and regional director of clinical services were notified of the issue regarding Resident #92's medications.

The facility policy/procedure titled, "General Dose Preparation and Medication Administration" read in part, "...Verify each time a medication is

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F 684	Continued From page 27 administered that it is the correct medication, at the correct time...Confirm that the MAR reflects the most recent medication order...Administer medication within timeframes specified by facility policy..." On 08/08/19 at approximately 4:04 p.m., during a meeting with the administrator, DON, regional vice president of operations, and regional director of clinical services the DON verbalized to the surveyor that the medication guidelines were that a medication could been administered one hour before or one hour after their scheduled time. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		9/18/19

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F 690	Continued From page 28 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure that this resident who is continent of bladder received services and assistance to maintain continence by following physician's orders in regards to a foley catheter care for 1 of 27 residents, Resident #66. The findings included: The facility staff failed to anchor Resident #66's foley catheter per the physicians order. The clinical record review revealed that Resident #66 had been admitted to the facility 02/28/17. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, chronic kidney disease, type 2 diabetes, schizoaffective disorder, Alzheimer's disease, obstructive and reflux uropathy, benign prostatic hyperplasia, and bipolar disorder.	F 690	The catheter anchor was replaced on resident #66 immediately. The Nursing Unit Managers conducted a 100% audit of all residents with catheters to ensure that all anchors were in place. All clinical staff was educated on how to monitor catheter anchors to assure that they are appropriately anchored. Nursing Unit Managers will conduct rounds 5 days a week for three months to assure that catheter anchors are properly attached. Quality Assurance and Performance Improvement Committee will review weekly until deficient practice is cleared.	

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F 690	Continued From page 29	F 690		

Section C (cognitive patterns) of the resident's significant change in status MDS (minimum data set) assessment included a BIMS (brief interview for mental status) summary score of 13 out of a possible 15 points. Section H (bladder and bowel) was coded to indicate the resident has a catheter.

Attempts to interview the resident were unsuccessful.

The resident's EHR (electronic health record) included a physicians order to anchor catheter tubing and check placement every shift.

The resident's comprehensive care plan included the focus area risk for complication in urinary system related to foley catheter use. Interventions included, but were not limited to, "anchor catheter tubing and check placement every shift."

On 08/08/19 at 7:40 a.m., the surveyor and CNA (certified nursing assistant) #5 checked the resident's foley catheter. This foley catheter was not anchored.

On 08/08/19 at 2:26 p.m., the surveyor and LPN (licensed practical nurse) #2 again checked this foley catheter. The foley catheter was now anchored. LPN #2 verbalized to the surveyor that one of the CNA's had put the strap in place.

On 08/08/19 at 3:35 p.m., CNA #4 stated she thought CNA #5 had put the strap in place.

On 08/08/19 at approximately 4:04 p.m., the administrator, DON, regional vice president of operations, and regional director of clinical services were notified of the issue regarding

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F 690	Continued From page 30 Resident #66's foley catheter not being anchored. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure that a resident who needs respiratory care is provided such care storing oxygen equipment appropriately for 2 of 27 residents in the sample survey (Resident #32 and # 82). The findings included: 1. The facility staff failed to store a nebulizer mask appropriately when not in use for Resident #32. Resident #32 was admitted to the facility on 5/28/18 with the following diagnosis of, but not limited to anemia, high blood pressure, renal disease, dementia, anxiety disorder, depression and respiratory failure. On the annual MDS (Minimum Data Set) with an ARD (Assessment	F 695	The suctioning devises for resident #32 and resident #82 were placed in storage bags and placed at bedside immediately. Nursing Unit Managers completed a 100% audit of all residents receiving supplemental O2, nebulizer treatments and suctioning to assure that all devises are stored appropriately. Current clinical staff were educated on the appropriate storage of supplemental O2, nebulizer treatment, and suctioning devises. Nursing Unit Managers will conduct rounds 5 days a week to assure that supplemental O2, nebulizer treatment, and suctioning devises are stored	9/18/19

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F 695	Continued From page 31 Reference Date) of 5/24/19, the resident was coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and bathing. On 8/7/19 at 8:21 am, the surveyor accompanied LPN (licensed practical nurse) #2 into Resident #32's room to observe the medication pass. Upon entering the room, the surveyor observed the nebulizer mask laying on the bedside table and was not stored in a plastic bag. The surveyor asked LPN #2 how the nebulizer mask was to be stored when not in use by the resident. LPN #2 stated, "The mask of the nebulizer is to be stored in a plastic bag." At 9:30 am, the surveyor notified the DON (director of nursing) and the regional nurse consultant of the above documented findings. On 8/8/19 at 4:22 pm, the surveyor notified the administrative team of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 8/9/19. 2. The facility staff failed to ensure Resident #82's respiratory treatment mask and oral suction catheters were appropriately stored. Resident #82 was admitted on 5/13/16. Resident #82's diagnoses included, but were not limited to: anemia, high blood pressure, Alzheimer's Disease, and respiratory failure. Resident #82's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/16/19 assessed the resident being unable to obtain a BIMS (brief interview for mental status) score due to the	F 695	appropriately. Quality Assurance and Performance Improvement Committee will review weekly until deficient practice is cleared.	

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F 695	Continued From page 32	F 695		

resident is rarely/never understood; this assessment also documented the resident as being dependent on facility staff for bed mobility, dressing, eating, toileting, and personal hygiene.

On 8/6/19 at 2:52 p.m., the following was observed:
- the suction canister at Patient #82's bed side had been used but was not dated,
- a yankauer suction catheter was lying uncovered on a towel on Patient #82's beside table,
- a flexible suction catheter was lying uncovered on a towel on Patient #82's bedside table,
- a mask for providing breathing treatments was lying uncovered on a towel on Patient #82's beside table, and
- a plastic bag was in floor beside Patient #82's bed side table.

The failure of facility staff to ensure Resident #82's respiratory treatment/suction equipment was correctly stored was discussed on 8/8/19 at 4:05 p.m. during a survey team meeting with the facility's Administrator, Director of Nursing (DON), Regional Director of Clinical Services (RDCS), and Regional Vice-President of Operations. The RDCS reported there was not a written policy and procedure to guide the storage of the aforementioned respiratory equipment. The DON reported the respiratory treatment mask should be changed weekly and kept stored in a bag, the yankauer suction catheter should be changed daily, and the flexible suction catheter should be discarded after use.

During a survey team meeting with the facility's Administrator, Director of Nursing (DON), Regional Director of Clinical Services (RDCS),

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F 695	Continued From page 33 and Regional Vice-President of Operations on 8/9/19 at 9:45 a.m., the DON reported Resident #82's daughter suctions the patient and had been previously been provided education about the use/storage of the respiratory equipment. The surveyor asked for documentation of education provided to the resident's daughter. The following information, found in Patient #82's care plan, was provided to the surveyor: "Daughter observed suctioning resident ... Daughter education to ask nursing for suctioning PRN (as needed)." No further information was provided to the surveyor prior to the exit conference on 8/8/19.	F 695		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 756		9/18/19

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F 756	Continued From page 34 and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to report any irregularities to ensure that drug regiment review recommendations were reported to the attending physician, facility medical director, and/or the director of nursing for 1 of 27 residents, Resident #3. The findings included: The facility staff failed to ensure the attending physician, facility medical director, and DON (director of nursing) reviewed and/or acted on a pharmacy recommendation for April 2019. The clinical record review revealed that Resident #3 had been admitted to the facility 06/23/15. Diagnoses included, but were not limited to, dysphagia, peripheral vascular disease, chronic kidney disease, hypertension, and diabetes.	F 756	The attending physician for resident #3 immediately addressed the pharmacy recommendation. The Director of Nursing conducted a 100% review of all pharmacy recommendations to assure they were addressed timely by the attending physicians The Director of Nursing met with medical staff to review the procedure for appropriate follow-up for the pharmacy recommendations. The Director of Nursing and Unit Managers will audit pharmacy recommendations weekly for 3 months to assure physician follow-up. Quality Assurance and Performance	

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F 756	Continued From page 35 Section C (cognitive patterns) of the resident's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/30/19 included a BIMS (brief interview for mental status) summary score of 9 out of a possible 15 points. The resident's EHR (electronic health record) was reviewed on 08/06-08/08/19. The EHR included a "Pharmacy Review Note" dated 04/16/19. The pharmacist had documented "See report for any noted irregularities and/or recommendations." On 08/08/19 at 12:13 p.m., the DON (director of nursing) was made aware that the surveyor needed to review the pharmacy recommendations for 04/16/19. On 08/08/19 at 1:46 p.m., the DON verbalized to the surveyor that she had reviewed her reports and she did not have anything for the date of 04/16/19. On 08/08/19 at approximately 4:04 p.m., the administrator, DON, regional vice president of operations, and regional director of clinical services were notified of the missing pharmacy recommendation. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 756	Improvement Committee will review weekly until deficient practice is cleared.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General.	F 757		9/18/19

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F 757	Continued From page 36 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure 1 of 27 resident was free of unnecessary medications. The findings included: 1. For Resident #25 the facility staff failed to ensure the resident was free of an unnecessary administration of insulin. Resident #25 was admitted to the facility on 01/23/18 and readmitted on 08/03/19. Diagnoses included but not limited to hypertension, obstructive uropathy, diabetes mellitus, dementia, Parkinson's disease, depression, acute kidney	F 757	The attending physician for resident #25 was immediately notified of the insulin being administered outside parameters. No new orders were received. Residents receiving insulin were reviewed by the nursing Unit Managers to assure that insulin is administered according to physician ordered blood sugar parameters. Current licensed nurses were educated on administering medications within the physician ordered blood sugar parameters.	

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F 757	Continued From page 37 failure and gastroesophageal reflux disease. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/24/19 assigned the resident a BIMS (brief interview for mental status) score of 6 out 15 in section C, cognitive status. Resident #25's comprehensive care plan was reviewed and contained a care plan for "Resident is at risk for hypo/hyperglycemia episodes R/T (related to): IDDM (insulin dependent diabetes mellitus)." Interventions for this care plan include medication as ordered. Resident #25's clinical record was reviewed on 08/07/19. It contained a signed physician's order summary for the month of August 2019, which read in part "Humalog Kwickpen 3 ml 100.units/ml. Inject 10 units subcutaneously two times a day for DM (diabetes mellitus). Hold if BS (blood sugar) < (less than) 140." Resident #25's eMAR (electronic medication administration record) for the months of July and August 2019 were reviewed. The eMAR's contained an entry, which read in part, "Humalog Kwickpen 3 ml 100 units/1 ml Unit. Inject 10 unit subcutaneously two times a day for DM. Hold if BS <140." The blood sugar for 07/04/19 at 9:00 AM was recorded as 122, and the entry was signed as insulin administered. The blood sugar for 07/09/19 at 9:00 AM was recorded as 126 and the entry was signed as insulin administered. The blood sugar for 08/05/19 was recorded as 126 and the entry was signed as insulin administered. The blood sugar for 08/07/19 was recorded as 128, and the entry was signed as insulin administered.	F 757	Nursing Unit Managers will monitor the administration of insulin 5 days a week for three months to assure that it is being given within ordered parameters. Quality Assurance and Performance Improvement Committee will review weekly until deficient practice is cleared.	

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F 757	Continued From page 38 The surveyor spoke with RN #1 on 08/08/19 at approximately 3:35 PM regarding Resident #25's insulin. Surveyor asked RN #1 what a check and initials indicated on the eMAR, and she stated that it meant the medication was administered as ordered. Surveyor then asked RN #1 to look at Resident #25's eMAR for the dates indicated above. RN #1 stated that the resident's insulin should not have been administered on these dates. The concern of unnecessarily administering the resident's insulin was discussed with the administrative staff (administrator, director of nursing, regional nurse consultant, and regional vice-president of operations) during a meeting on 08/08/19 at approximately 4:00 PM. No further information was provided prior to exit.	F 757		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure a medication error rate was less than 5% for 3 of 27 residents in the survey sample. There were 29 opportunities for error with 3 medication errors noted by the surveyors that made the medication error rate of 10.34% (Resident #32, #9 and #50).	F 759	The attending physicians for residents #32, #9 and #50 were notified of the errors made during the med pass immediately. New orders were received. LPN #2, #1, and #11 received immediate educated on the errors made during the medication pass.	9/18/19

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F 759	Continued From page 39 The findings included: 1. The surveyor observed LPN (licensed practical nurse) #2 crush a Mucinex DM and administer this to Resident #32. Resident #32 was admitted to the facility on 5/28/18 with the following diagnosis of, but not limited to anemia, high blood pressure, renal disease, dementia, anxiety disorder, depression and respiratory failure. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/24/19, the resident was coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and bathing. On 8/7/19 at 8:21 am, the surveyor was observing LPN #2 administrating medication to Resident #32. During this observation, LPN #2 crushed the medication Mucinex DM and administrated it to the resident. At 9:35 am, the surveyor spoke to the pharmacist on the phone. The pharmacist stated that the Mucincex DM was not to be crushed because it is an extended release tablet that cannot be crushed. At 10:30 am, the surveyor notified the DON (director of nursing) and the regional nurse of the above documented observations. The DON stated, "I don't believe that you can crush that. The surveyor requested the Do Not Crush list that the facility staff is to use. The surveyor reviewed the clinical record for Resident #32 at 1 pm. The resident did have a physician order, which stated, " ...Mucinex DM 1	F 759	Nursing Unit Managers conducted a 100% audit of all medication administration passes to assure that medications were being passed according to the instructions on the medication administration record. Current licensed nurses were educated on medication passes in accordance with the medication administration record. Nursing Unit Managers will audit licensed nurses compliance with the medication administration 5 percent of nursing staff weekly for three months. Quality Assurance and Performance Improvement Committee will review weekly until deficient practice is cleared.	

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F 759	Continued From page 40	F 759		

tablet every BID (twice a day) po (by mouth) ..."

The surveyor received a copy of the Do Not Crush medication list at 1:30 pm from the DON. On this list, the surveyor noted that Mucinex DM was included as one of the medications that is not to be crushed.

The surveyor notified the administrative team of the above documented findings on 8/8/19 at 4:22 pm.

No further information was provided to the surveyor prior to the exit conference on 8/9/19.

2. The surveyor observed LPN #1 administrating Flonase nasal spray to Resident #9. LPN #1 did not have Resident #9 to blow her nose before the administration of this medication.

Resident #9 was readmitted to the facility on 1/29/17 with the following diagnoses of heart failure, depression and asthma. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/8/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #9 was also coded as requiring supervision of 1 staff member for dressing and personal hygiene and extensive assistance of 1 staff member for bathing.

During the medication pass and pour observation on 8/7/19 at 8:43 am, the surveyor observed LPN (licensed practical nurse) #1 administrating Flonase nasal spray to Resident #9. The medication was given as ordered by the physician but LPN did not have the resident blow her nose before administrating this nasal spray to the

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resident.
At 8:55 am, the surveyor asked LPN #1 if the resident was to blow her nose before she was given the nasal spray, Flonase. LPN #1 stated, "I thought I did that." The surveyor stated, "No I didn't observe you asking or instructing the resident to do this before you gave the resident the Flonase."

At 11 am, the surveyor notified the DON (director of nursing) of the above documented observations. The surveyor requested a copy of the package insert for the medication Flonase.

At 11:30 am, the DON gave the surveyor the package insert for Flonase. The surveyor noted the following on the package insert which stated, " ...Blow your nose to clear your nostrils ..."

The surveyor notified the administrative team of the above documented findings on 8/8/19 at 4:22 pm.

No further information was provided to the surveyor prior to the exit conference on 8/9/19.
3. Resident #50 was administered a crushed medication that should not have been crushed.

Resident #50 was admitted to the facility on 3/17/15. Resident #50's diagnoses included, but were not limited to: anemia, hyponatremia, seizure disorder or epilepsy, and respiratory failure.

Resident #50's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/15/19 assessed the resident with a BIMS (brief interview for mental status) score of 7 out of 15; this assessment also

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F 759	Continued From page 42 documented the resident's urinary continence as always incontinent. On 8/8/19 at 7:45 a.m., LPN (licensed practical nurse) #11 was observed administering Resident #50's medication. One of the medications that was crushed before it was administered to Resident #50 was Oxybutynin 5mg. Resident #50's clinical record included the following medication order: "Oxybutynin Chloride ER Tablet Extended Release 24 hours 5 MG Give 5 mg by mouth one time a day for Bladder Spasms DO NOT CRUSH". On 8/8/19 at 8:25 a.m., LPN #11 was interviewed about which of Resident #50's medication he/she had crushed. LPN #11 reported he/she had crushed all the observed medications "except the potassium". On 8/8/19 at 8:35 a.m., the facility's Director of Nursing (DON) was interviewed about Resident #50 having his/her Oxybutynin crushed prior to administration. The DON reviewed Resident #50's orders then confirmed the Oxybutynin should not have been crushed. The observation of Resident #50 being administered a crushed medication that should not have been crushed was discussed during a survey team meeting with the facility's administrative team on 8/8/19 at 4:05 p.m.; the facility's administrative team at this meeting included the Administrator, the DON, the Regional Director of Clinical Services, and the Regional Vice-President of Operations.	F 759		
F 760	Residents are Free of Significant Med Errors	F 760		9/18/19

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F 760 SS=D	Continued From page 43 CFR(s): 483.45(f)(2) 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 resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure 2 of 27 residents were free of significant medication errors involving insulin. Residents #92 and #25. The findings included: 1. For Resident #92, the facility staff failed to administer the resident's insulin until the resident verbalized a concern to the surveyor during a group interview. The clinical record review revealed that Resident #92 had been admitted to the facility 08/21/17. Diagnoses included, but were not limited to, difficulty in walking, type 2 diabetes, dysphagia, essential hypertension, and dysphagia. Section C of the resident's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/03/19 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The resident's EHR (electronic health record) was reviewed on 08/07/19 after a concern brought up in the group meeting regarding not receiving her morning insulin. On 08/07/19 at 11:21 a.m., Resident #92 verbalized to the surveyor that she had not	F 760	The attending physicians for residents #92 and #25 were immediately notified of the medication errors. No new orders were given. Nursing Unit Managers conducted a 100% audit of all medication administration passes to assure that medications were being passed according to the instructions on the medication administration record. Current licensed nurses were educated on medication passes in accordance with the medication administration record with emphasis on insulin administration according to physician orders. Nursing Unit Managers will audit licensed nurses compliance with the medication administration 5 percent of nursing staff weekly for three months. Quality Assurance and Performance Improvement Committee will review weekly until deficient practice is cleared.	

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received her morning insulin. Resident #92 stated the nursing staff had checked her BS (blood sugar) but she did not get her insulin. When asked if she felt okay, Resident #92 stated she did and stated her BS was 227.

The surveyor immediately spoke with the administrator and LPN (licensed practical nurse) #1. LPN #1 verbalized to the surveyor that the resident had not received her insulin as she had not been in her room and she was unable to find her. LPN #1 stated the resident's insulin was due to be administered at 10:00 a.m.

On 08/07/19 at 11:32 a.m., LPN #6 verbalized to the surveyor that she had just administered the resident's medications to included insulin.

A review of the resident's eMARs (electronic medication administration records) revealed that the resident was due to receive18 units of lantus insulin for diabetes at 9:00 a.m.; the resident's BS had been obtained at 6:30 a.m. and had been documented as being 226. LPN #1 had signed for the insulin at 9:00 a.m. as if it had been administered.

There was no medication scheduled for 10:00 a.m. as LPN #1 stated.

08/07/19 at 2:52 p.m., when asked why she had signed for the resident's medications as if they had been administered LPN #1 stated you can check yes, you can hit lock, or save and apparently I hit the save button instead of the lock button. LPN #1 stated she had relieved an agency nurse when she took report and there was not a whole lot the previous nurse could tell me about the unit.

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On 08/07/19 at approximately 4:08 p.m., the administrator, DON (director of nursing), regional vice president of operations, and regional director of clinical services were notified of the issue regarding Resident #92's medications.

The facility policy/procedure titled, "General Dose Preparation and Medication Administration" read in part, "...Verify each time a medication is administered that it is the correct medication, at the correct time...Confirm that the MAR reflects the most recent medication order...Administer medication within timeframes specified by facility policy..."

On 08/08/19 at approximately 4:04 p.m., during a meeting with the administrator, DON, regional vice president of operations, and regional director of clinical services the DON verbalized to the surveyor that the medication guidelines were that a medication could been administered one hour before or one hour after their scheduled time.

The facility nursing staff had documented the resident's BS at 4:30 p.m. as being 221.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. For Resident #25 the facility staff failed to ensure the resident was free of a significant medication error.

Resident #25 was admitted to the facility on 01/23/18 and readmitted on 08/03/19. Diagnoses included but not limited to hypertension, obstructive uropathy, diabetes mellitus, dementia, Parkinson's disease, depression, acute kidney

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failure and gastroesophageal reflux disease.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/24/19 assigned the resident a BIMS (brief interview for mental status) score of 6 out 15 in section C, cognitive status.

Resident #25's comprehensive care plan was reviewed and contained a care plan for "Resident is at risk for hypo/hyperglycemia episodes R/T (related to): IDDM (insulin dependent diabetes mellitus)." Interventions for this care plan include medication as ordered.

Resident #25's clinical record was reviewed on 08/07/19. It contained a signed physician's order summary for the month of August 2019, which read in part "Humalog Kwickpen 3 ml 100.units/ml. Inject 10 units subcutaneously two times a day for DM (diabetes mellitus). Hold if BS (blood sugar) < (less than) 140."

Resident #25's eMAR (electronic medication administration record) for the months of July and August 2019 were reviewed. The eMAR's contained an entry, which read in part, "Humalog Kwickpen 3 ml 100 units/1 ml Unit. Inject 10 unit subcutaneously two times a day for DM. Hold if BS <140." The blood sugar for 07/04/19 at 9:00 AM was recorded as 122, and the entry was signed as administered. The blood sugar for 07/09/19 at 9:00 AM was recorded as 126 and the entry was signed as administered. The blood sugar for 08/05/19 was recorded as 126 and the entry was signed as administered. The blood sugar for 08/07/19 was recorded as 128, and the entry was signed as administered.

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F 760	Continued From page 47 The surveyor spoke with RN #1 on 08/08/19 at approximately 3:35 PM regarding Resident #25's insulin. Surveyor asked RN #1 what a check and initials indicated on the eMAR, and she stated that it meant the medication was administered as ordered. Surveyor then asked RN #1 to look at Resident #25's eMAR for the dates indicated above. RN #1 stated that the resident's insulin should not have been administered on these dates. The concern of not ensuring Resident #25 was free of a significant medication error was discussed with the administrative staff (administrator, director of nursing, regional nurse consultant, and regional vice-president of operations) during a meeting on 08/08/19 at approximately 4:00 PM. No further information was provided prior to exit.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		9/18/19

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F 761	Continued From page 48 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to appropriately store medications in 2 of 5 medication carts in the nursing facility (Unit 1 and 2 Elevator Day Medication Carts) and failed to store madications by keeping medication cart locked during the medication administration observation when the nurse was not in view of this cart (Medication Cart Elevator Day #1). The findings included: 1. To appropriately store medications in 2 of 5 medication carts in the nursing facility. (Unit 1 and 2 Elevator Day Medication Carts) On 8/7/19 at 11:10 am, the surveyor and DON (director of nursing) observed the following pills loose in the medication cart drawer on Unit 1, Elevator Day Medication Cart on 1st floor (these were noted in the 2nd drawer): " (1) small round beige in color pill " (1) beige tablet oblong pill " (1) medium size beige pill " (1) tan colored round pill	F 761	On August 7, 2019 all medication carts were checked. All lose medications were removed. The Director of Nursing conducted a 100% of all medication carts to assure that there were no lose medications. Current Licensed Nurses were educated on the appropriate cleanliness and maintenance of the medication carts. Nursing Unit Managers will audit medication carts weekly for three months to assure compliance Quality Assurance and Performance Improvement Committee will review weekly until deficient practice is cleared.	

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At 11:30 am, the surveyor and DON observed the following loose pill in the medication cart drawer on Unit 2, Elevator Day Medication Cart on 2nd floor:

" 2nd drawer 1/2 small greenish pill

The DON stated to the surveyor, "When a nurse sees a pill loose in the med cart, they are to discard the medication."

At 4:22 pm, the surveyor notified the administrative team of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 8/9/19.

2. To keep medication cart locked during the medication administration observation when the nurse was not in view of this cart. (Medication Cart Elevator Day #1)

On 8/7/19 at 08/07/19 at 08:18 am LPN (licensed practical nurse #2) was observed by the surveyor administer medications to a resident in their wheelchair that was located between room 203 and 205. While LPN #2 was administrating the medications, she left her medication cart (Medication Cart Elevator #1) unattended and unlocked and she turned her back away from the cart. The surveyor observed that the nurse could not visual see the medication cart.

At 10 am, the surveyor notified LPN #2 of the above documented findings. LPN #2 stated, "I didn't realize that I did that. I usually always lock my cart."

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F 761	Continued From page 50 At approximately 2 pm, the surveyor notified the DON (director of nursing) of the above documented findings The DON stated, "You never leave your medication cart unlocked when you are not right with it." At 4:22 pm, the surveyor notified the administrative team of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 8/9/19.	F 761		
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	F 842		9/18/19

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

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

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

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

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F 842	Continued From page 52 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 2 of 27 residents in the survey sample (Resident #122, and #110). The findings included: 1. The facility staff failed to ensure a complete and accurate clinical record in regards to behavioral monitoring for Resident #122. Resident #122 was readmitted to the facility on 7/18/19 with the following diagnoses of, but not limited to atrial fibrillation, neurogenic bladder, pneumonia, dementia, Multiple Sclerosis, seizure disorder and anxiety disorder. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/24/19; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 9 out of a possible score of 15. Resident #122 was also coded as being dependent on 1 or 2 staff members for dressing, personal hygiene and bathing. The surveyor conducted a review of Resident #122's clinical record on 8/7 and 8/8/19. During this review, the surveyor noted the resident was receiving Ativan 1 milligram at bedtime for anxiety disorder. The surveyor reviewed the "Behavior/Intervention Flow Record" for the month of August 2019. The information documented did not match the facility form's key on Resident #122.	F 842	The attending physician for resident #122 was notified concerning the inappropriate documentation on the behavior monitoring sheet on August 8, 2019. No new orders received. The attending physician for resident #110 was notified concerning the bowel sheet on August 8, 2019. No new orders received. Nursing Unit Managers conducted a 100% audit of all resident behavior sheets and bowel sheets to assure that nurses were documenting and contacting physicians according to facility policy. Current licensed nurses were educated concerning documenting according to the legend on the behavior sheet and on physician notification on the bowel sheet. Nursing Unit Managers will conduct weekly audits for 3 months of behavior and bowel flow sheets to assure compliance with facility policy. Quality Assurance and Performance Improvement Committee will review weekly until deficient practice is cleared.	

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F 842	Continued From page 53	F 842		

The surveyor notified the DON (director of nursing) on 8/8/19 at 1:27 pm. The DON stated, "We have educated and educated these nurses on what and how to document using the key on the behavior form. I just have a bunch of new nurses and that's why we are seeing this."

The surveyor notified the administrative team of the above documented findings on 8/8/19 at 4:22 pm.

No further information was provided to the surveyor prior to the exit conference on 8/9/19.
2. The facility staff failed to ensure Resident #110's clinical record correctly captured the individual(s)/provider(s) who gave orders for MiraLax Powder, a Dulcolax tablet, and to discontinue (d/c) a colonoscopy.

Resident #110 was admitted on 3/29/18. Resident #110's diagnoses included, but were not limited to: high blood pressure, arthritis, dementia, and renal disease.

Resident #110's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/18/19 assessed the resident with a BIMS (brief interview for mental status) score of 0 out of 15; this assessment also documented the resident as usually able to express ideas and wants and sometimes able to understand others.

Resident #110's clinical record included provider orders for MiraLax powder, a Dulcolax tablet, and to discontinue (d/c) a colonoscopy. The orders read as if Physician #4 had given the three (3) aforementioned orders.

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On 08/08/19 at 12:35 p.m., Physician #4 was interviewed via telephone. When asked about the three (3) aforementioned orders, Physician #4 reported he/she did not give the orders. Physician #4 stated he/she was out of country on 7/25/19 when the order to discontinue (d/c) the colonoscopy was given. Physician #4 reported the orders for the Miralax and Dolcolax would have been given by individuals from the facility performing the colonoscopy.

During an interview on 8/8/19 at 12:40 p.m., Licensed Practical Nurse (LPN) #12 and LPN #14 reported when taking a verbal order from someone who is covering for a facility provider, the order is entered as being given by the PCP (primary care provider). The surveyor requested a copy of the facility's policy and procedure to guide obtaining this type of verbal order.

On 8/8/19 at 1:25 p.m., the facility's administrator reported the facility's electronic order system will not allow an order to be entered by some consulting providers, therefore the facility staff enters the order under the PCP's name.

On 8/8/19 at 2:40 p.m., LPN #12 provided the surveyor with a copy of the preparation instructions sent by the providers who were scheduled to complete Resident #110's colonoscopy. LPN #12 reported the facility's staff was unable to enter the colonoscopy prep orders into the facility's electronic order system under the name of a provider who does not have access to sign the orders in the electronic system. LPN #12 reported it was not an expectation that staff would call a facility provider to confirm the order due to the provider reviewing orders when he/she comes to the facility.

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F 842	Continued From page 55 On 8/8/19 at 2:52 p.m., the Regional Director of Clinical Services (RDCS) reported orders received from a provider, other than the ones allowed to give orders at the facility, have to be reviewed with a provider who is able to give orders prior to the orders being entered into the electronic system. The RDCS reported the facility had no written policy/procedure to guide the process of obtaining orders from a provider not allowed to give orders at the facility. The facility's Medical Director (MD) was interviewed on 8/9/19 at 8:53 a.m. The MD reported, when taking orders from a consulting/specialist provider, the facility staff should verbally contact the provider whose name the order will be entered under prior to entering the order into the facility's electronic order system.	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in	F 849		9/18/19

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paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.

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F 849	Continued From page 57 (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.	F 849		

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§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice

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F 849	Continued From page 59 personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to coordinate care with Hospice services for 2 of 25 residents in the survey sample (Resident #122 and #71). The findings included: 1. The facility did not have the hospice clinical notes and care plan available for review by the surveyor for Resident #122. Resident #122 readmitted to the facility on 7/18/19 with the following diagnoses of, but not limited to atrial fibrillation, blood clot, neurogenic bladder, pneumonia, septicemia and dementia.	F 849	The hospice care plan for resident #122 was obtained from the hospice provider on August 9, 2019. The DON and Unit Managers conducted a 100% audit of all hospice residents medical record to assure the hospice care plans are available. Date Regional Director of Clinical Service educated the MDS Coordinator to insure that the hospice care plan is available for reference to clinical staff. The MDS Coordinator will audit hospice	

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F 849	Continued From page 60 On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/24/19; the resident was coded having a BIMS (Brief Interview for Mental Status) score of 9 out of a possible score of 15. Resident #122 was also coded as being dependent on 1-2 staff members for dressing, personal hygiene and bathing. During the clinical record review on 8/7/19, the surveyor could not locate the Hospice care plan, aide or nursing notes for the visits that the hospice staff has provided to this resident. At 3:51 pm, the surveyor notified the regional nurse of the above documented findings. The regional nurse looked into the hospice notebook located on the nursing unit and she could not find these notes either. She stated that she would notify the DON (director of nursing) about this and get back with the surveyor. On 8/8/19 at 2 pm, the surveyor received copies of the nurses and aides' notes along with the Hospice plan of care. The DON stated that the hospice company brought these notes to the facility on the evening of 8/7/19. No further information was provided to the surveyor prior to the exit conference on 8/9/19. 2. The facility did not have the hospice clinical notes and care plan available for review by the surveyor for Resident #71. Resident #71 was readmitted to the facility on 9/12/18 with the following diagnoses of, but not limited to anemia, high blood pressure, dementia and respiratory failure. On the quarterly MDS	F 849	resident charts weekly for three months to ensure that care plans can be referenced by clinical staff. Quality Assurance and Performance Improvement Committee will review weekly until deficient practice is cleared.	

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F 849	Continued From page 61 (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/29/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #71 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 2 staff members for bathing. During the clinical record review on 8/8/19, the surveyor noted there were no hospice clinical notes available for review after 7/22/19. This was the last visit that had been made by the hospice company. At 3:06 pm, the surveyor notified the DON (director of nursing) of the above documented findings. On 08/09/19 09:45 am the surveyor was given a copy of a hospice nursing note dated for 7/30/19 by the DON. The DON stated to the surveyor that the hospice company brought this to the facility last night (8/8/19) after they were called. The surveyor notified the administrative team of the above documented findings on 8/9/19 at 10 am. No further information was provided to the surveyor prior to the exit conference on 8/9/19.	F 849		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		9/18/19

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comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

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

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

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

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	495126	A. BUILDING _____ B. WING _____	08/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADDELL NURSING AND REHAB CENTER	202 PAINTER ST GALAX, VA 24333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 63 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to maintain an infection control program designed to provide a sanitary practices by ensuring that infection control practices were followed during the medication pass and pour observation on 1 of 3 units in the nursing facility (Unit #1 on 1st floor). The findings included: On 8/7/19 at 8:43 am, the surveyor observed LPN (licensed practical nurse) #1 prepare and administer medications to Resident #57 during the medication pass and pour observation. The surveyor did not observe LPN #1 wash her hands before or after administrating the medications to	F 880	The attending physician for residents #57 and #9 was informed of the deficient practice on August 7, 2019. No orders were given. LPN #1 was immediately counseled concerning infection control procedures on August 7, 2019. Nursing Unit Managers conducted a 100% audit of all medication administration passes to assure that infection control protocols were being followed. Current staff are educated on proper hand washing techniques and infection prevention.	

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F 880	Continued From page 64 this resident. At 8:55 am, the surveyor again observed LPN #1 preparing and administrating medications to Resident #9 during the medication pass and pour observation. The surveyor did not observe LPN #1 washing her hands before or after administrating medications to this resident. The surveyor asked LPN #1 when she should wash her hands. LPN #1 stated, "You are to wash your hands between residents." The surveyor notified LPN #1 that she was not observed in washing her hands before or after administrating medications to Resident #57 and Resident #9. At 9:29 am, the surveyor notified the DON (director of nursing) and the regional nurse consultant of the above documented findings. The surveyor requested a copy of the facility's policy on hand washing during medication administration. The surveyor received a copy of the facility's policy titled, "Hand Washing" which read in part, " ...Wash hands with either plain or antimicrobial soap and water or rub hands with an alcohol-based formulation before handling medication ..." The surveyor notified the administrative team of the above documented findings on 8/7/19 at 4:22 pm. No further information was provided to the surveyor prior to the exit conference on 8/9/19.	F 880	Nursing Unit Managers will conduct daily observation rounds to assure that staff members are exercising infection prevention techniques 5 times a week for 3 months. Quality Assurance and Performance Improvement Committee will review weekly until deficient practice is cleared.	