| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495186 | A. BUILDING _____ B. WING _____ | C 10/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BETH SHOLOM HOME OF EASTERN VI | 6401 AUBURN DR VIRGINIA BEACH, VA 23464 |

| (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 |
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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 10/08/19 through 10/10/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long Term Care Facilities. No emergency preparedness complaints were investigated during the survey. | E 000 | | |
| E 025 SS=C | Arrangement with Other Facilities<br>CFR(s): 483.73(b)(7)<br><br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]<br><br>*[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.<br><br>*[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of | E 025 | E025<br><br>1. No residents were cited as a result of the failure to provide documentation that the facility's Emergency Preparedness Plan (EPP) included arrangements for transportation of residents in the event of an evacuation. Administrator placed calls to tri-state areas for transportation arrangements.<br><br>2. All residents have the potential to be affected by this finding.<br><br>3. The Administrator will identify and obtain the necessary transportation company(ies) that will meet the requirements of the facility's evacuation needs. The EPP will be updated to include the name(s) and number(s) of the company(ies) participating in the EPP evacuation transportation event.<br><br>4. The EPP transportation agreement(s) will be reviewed quarterly by the QAPI committee. Non-compliance will be addressed through further education and/or disciplinary action as appropriate.<br><br>5. Our corrective action plan will be in place by 11/8/19. | |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca Moseley — TITLE: RN Administrator — (X6) DATE: 10/31/19

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

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| E 025 | Continued From page 1<br>operations to maintain the continuity of services to facility patients.<br><br>*[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility staff failed to have documentation of arrangements for transportation in the event of an evacuation.<br><br>The findings included:<br><br>During the Emergency Preparedness review on 10/10/19 at 9:40 A.M. with the Administrator, she was asked for policies and procedures which include prearranged agreements for transportation. The Administrator stated, the facility had not included pre-arranged agreements for transportation during an evacuation. | E 025 | | |
| E 039 SS=C | EP Testing Requirements<br>CFR(s): 483.73(d)(2)<br><br>(2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following:<br><br>*[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including | E 039 | E 039<br><br>1. No residents were cited as a result of the failure to analyze the response of drills, table top exercises or emergency events. The EPP committee conducted an analysis of a table exercise for winter storm snow/blizzard/ice preparedness on 10/29/19.<br><br>2. All residents have the potential to be affected by this finding. | |

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| E 039 | Continued From page 2<br>unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]<br><br>(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.<br>(ii) Conduct an additional exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, facility-based.<br>(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.<br><br>*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:<br>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set | E 039 | 3. The facility developed a written plan for analyzing the response to emergency drills and the EPP was revised. Responsible staff will be inserviced by the Staff Development Coordinator or designee on their roles and responsibilities by the compliance date.<br><br>4. The QAPI committee will review and analyze the table top exercises annually. Non-compliance will be addressed through further education and/or disciplinary action as appropriate.<br><br>5. Our corrective action plan will be in place by 11/8/19. | |

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| E 039 | Continued From page 3<br>of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility staff failed to have documentation of the additional exercise to include annual table top full scale exercise.<br><br>The findings included:<br><br>During the Emergency Preparedness Plan review with the Administrator at 10:15 A.M. on 10/10/19, she was asked for documentation of the facility's annual table top exercise. The Administrator stated the facility had not conducted an annual drill to test the emergency plan. | E 039 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 10/08/19 through 10/10/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey.<br><br>The census in this 120 certified bed facility was 97 at the time of the survey. The survey sample consisted of 48 resident reviews. | F 000 | | |
| F 623 SS=E | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8) | F 623 | | |

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| F 623 | Continued From page 4<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or | F 623 | F623<br><br>1. Discharge information for residents #11, #95, #107, #2, #114 was faxed to the state long term care ombudsman on 10/9/19.<br><br>2. All residents who are transferred or discharged from the facility have the potential to be affected. The ombudsman was notified via fax, all discharges from the facility dating back to 11/1/2017.<br><br>3. Our social services department reviewed the regulation with the ombudsman on 10/25/19. Our "Facility Initiated Transfer and Discharge" policy was revised on 10/28/19 to include ombudsman notification of all transfers/discharges from the facility. Social services, admissions and administrative staff was inserviced on the revised policy on 10/28/19.<br><br>4. Social services will audit all discharges monthly for a minimum of 90 days to ensure compliance. Any variance will be immediately corrected and a final discharge report will be sent. Results of the monthly audits will be reviewed monthly by the Administrator for a minimum of 90 days. Non-compliance will be addressed through further education and/or disciplinary action as appropriate.<br><br>5. Our corrective action plan will be in place by 11/8/2019. | |

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| F 623 | Continued From page 5<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice. | F 623 | | |

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| F 623 | Continued From page 6<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident record review, staff interviews and facility document review, the facility staff failed to notify the Office of the State Long-Term Care Ombudsman in writing of resident discharges for 5 of 48 residents (Resident #11, #95, #107, #2, and #114) after being transferred to the hospital.<br><br>The findings included:<br><br>1. Resident #11 was originally admitted to the facility on 03/04/15. The resident was re-admitted to the facility on 02/08/19. Diagnosis for Resident #11 included but not limited to Heart Failure Unspecified and Orthostatic Hypertension.<br><br>Resident #11's current Minimum Data Set (MDS), a quarterly revision with an Assessment Reference Date (ARD) of 06/12/19 coded the resident with a 7 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) | F 623 | | |

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| F 623 | Continued From page 7<br>indicating severe cognitive impairment.<br><br>The Discharge MDS assessment dated 02/06/19 - discharge return anticipated, resident re-admitted on 02/08/19. The was no evidence that the Ombudsman was notified of the discharge.<br><br>On 10/10/19 at approximately, 1:29 PM an interview was conducted with the facility Social Worker (Other Staff #3) concerning Ombudsman notifications of transfers and discharges. She stated, "We don't notify the Ombudsman of transfers and discharges." "We were not aware that we needed to do that." "We are not doing that across the board."<br><br>On 10/11/19 at approximately 5:15 p.m. a pre-exit interview was conducted with the administrator concerning the above residents. No comments were made.<br><br>2. Resident #95 was originally admitted to the facility on 01/03/18 and readmitted on 09/11/2019. Diagnoses for Resident #95 included but not limited to Anxiety Disorder, Major Depressive Disorder and Bipolar Disorder.<br><br>The most recent Minimum Data Set (MDS) assessment was a quarterly dated 08/21/19 coded the resident with having short-term and long-term memory problems which indicated the resident's cognitive skills for decision making is moderately impaired.<br><br>The Discharge MDS assessment dated 04/30/19 - discharge return anticipated, resident re-admitted on 05/09/19. The was no evidence that the Ombudsman was notified of the | F 623 | | |

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| F 623 | Continued From page 8<br>discharge.<br><br>On 10/10/19 at approximately, 1:29 PM an interview was conducted with the facility Social Worker (Other Staff #3) concerning Ombudsman notifications of transfers and discharges. She stated, "We don't notify the Ombudsman of transfers and discharges." "We were not aware that we needed to do that." "We are not doing that across the board."<br><br>On 10/11/19 at approximately 5:15 p.m. a pre-exit interview was conducted with the administrator concerning the above residents. No comments were made.<br><br>3. Resident #107 was admitted to facility on 8/5/2019 with a transfer occurring on 8/9/2019. The latest diagnosis included, but not limited to, chronic systolic (congestive) heart failure, peripheral vascular disease, unspecified, type 2 diabetes mellitus with other specified complication, chronic kidney disease, essential (primary) hypertension and malignant neoplasm of prostate.<br><br>Resident #107's most recent MDS (Minimum Data Set) assessment was a Quarterly Review Assessment with an ARD (assessment reference date) of 9/14/2019. Resident #107 was coded as moderate cognitive impairment scoring 11 out of possible 15 (brief interview for mental status) exam.<br><br>A review of Resident #107's clinical record revealed he was transferred to the hospital on 8/9/2019.<br><br>Clinical record reviews conducted yielded no | F 623 | | |

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| F 623 | Continued From page 9 | F 623 | | |

evidence that a notification of transfer was submitted to the ombudsman for hospitalization occurring on 8/9/2019. An interview was conducted with the Social Worker (Other Staff Member #3) on 10/10/2019 at approximately 1:29 p.m. regarding the status of the ombudsman notification of transfer for Resident #107, responding, "We were not aware that we needed to do that. We are not doing that across the board."

4. Resident #2 was admitted to the facility on 01/05/19 with diagnoses that included, but not limited to, history previous stroke and progressive MS (multiple sclerosis), depression and neuropathic bladder.

A 01/15/19 Initial Minimum Data Set (MDS) coded this resident in the area of Cognitive Patterns - Brief Interview Minimum Status (BIMS) score as a 9 which indicated moderate cognitive impairment.

A nursing note dated 12:01 PM on 04/11/19 indicated: "PA (physician assistant) in to see resident and order was given to send resident to ER (emergency room). Resident left facility at 12:30 via medical transport."

During an interview on 10/09/19 at 4:15 PM with the Social Worker, she stated, the Ombudsman had not been notified regarding Resident #2's discharge to the hospital on 04/11/19.

5. Resident #114 was admitted to the facility on 07/23/19. Diagnosis for Resident #114 included but not limited to Congestive Heart Failure. Resident #114's Discharge MDS with an Assessment Reference Date of 08/07/19 coded

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| F 623 | Continued From page 10<br>resident with a BIMS score of 15 out of a possible 15 indicating no cognitive impairment.<br><br>The Discharge MDS assessments was dated for 08/07/19-return not anticipated.<br><br>On 08/07/19, according to the facility's documentation, Resident #114 was discharged home accompanied by her daughter; transported via a private vehicle.<br><br>An interview was conducted with the Discharge Planner on 10/10/19 at approximately 1:27 p.m. She said she did not know the Ombudsman was to be notified of any resident discharges; as the Discharge Planner, which is something she should have known but was never told.<br><br>A briefing was held with the Chief Executive Officer (CEO) and Administrator on 10/10/19 at approximately 4:25 p.m. The surveyor reviewed the facility's policy titled Discharging the Resident (revision date 04/16/19) with the CEO and Administrator. The policy did not contain any information related to notifying the Ombudsman of resident discharges from the facility. The Administrator stated, "I will be revising the policy to include notification of the Ombudsman of all discharges from the facility." | F 623 | | |
| F 638 SS=D | Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c)<br><br>§483.20(c) Quarterly Review Assessment<br>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.<br>This REQUIREMENT is not met as evidenced | F 638 | F638<br><br>1. Resident #2's record was reviewed on 10/9/19 and the resident had no adverse affects and had no significant change in status during the time MDS assessment was missed. The missing MDS was completed and submitted on 10/30/19. | |

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| | 495186 | A. BUILDING _____ B. WING _____ | C 10/10/2019 |

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| BETH SHOLOM HOME OF EASTERN VI | 6401 AUBURN DR VIRGINIA BEACH, VA 23464 |

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| F 638 | Continued From page 11<br>by:<br>Based on record review and staff interview the facility staff failed to conduct quarterly assessments for one resident (Resident #2) in the survey sample of 48 residents.<br><br>The findings included:<br><br>Resident #2 was admitted to the facility on 01/05/19 with diagnoses that included, but not limited to, previous stroke and history of progressive MS (multiple sclerosis), depression and neuropathic bladder.<br><br>The Initial Minimum Data Set (MDS) dated 01/15/19, coded this resident in the area of Cognitive Patterns - Brief Interview Minimum Status (BIMS) score as a 9 which indicated moderate cognitive impairment.<br><br>A Care Plan updated 04/16/19 indicated: Cognition- potential late effects of comorbidities, forgetfulness, potential effects of current medication regimen. - Intervention- Staff to anticipate needs. Limit/structure choices to avoid frustration.<br><br>The clinical record was reviewed and the initial MDS was performed on 01/15/19, however there were no Quarterly MDS's for April or July 2019.<br><br>During an interview on 10/09/19 with the MDS Coordinator she stated, she missed the assessments and did not assess Resident #2. No further information was presented by facility staff. | F 638 | 2. All residents who required quarterly MDS assessments have the potential to be affected. An audit was conducted on current residents by Nursing Administration on all residents requiring MDS assessment and there were no other MDS omissions.<br><br>3. MDS Coordinator or designee will ensure all newly admitted resident have MDS assessments generated by EMR within 72 hours. The MDS policy has been reviewed and updated. Our MDS staff have been inserviced on the policy.<br><br>4. The QA Director or designee will complete weekly audits on all residents due for quarterly MDS assessments to ensure MDS's were initiated as appropriate. Results will be reviewed weekly by the QAPI committee for a minimu of 90 days. Non-compliance will be addressed through further education and/or disciplinary action as appropriate.<br><br>5. Our corrective action plan will be in place by11/8/19. | |
| F 640 SS=E | Encoding/Transmitting Resident Assessments<br>CFR(s): 483.20(f)(1)-(4) | F 640 | | |

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| F 640 | Continued From page 12<br><br>§483.20(f) Automated data processing requirement-<br>§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:<br>(i) Admission assessment.<br>(ii) Annual assessment updates.<br>(iii) Significant change in status assessments.<br>(iv) Quarterly review assessments.<br>(v) A subset of items upon a resident's transfer, reentry, discharge, and death.<br>(vi) Background (face-sheet) information, if there is no admission assessment.<br><br>§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.<br><br>§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:<br>(i)Admission assessment.<br>(ii) Annual assessment.<br>(iii) Significant change in status assessment.<br>(iv) Significant correction of prior full assessment.<br>(v) Significant correction of prior quarterly assessment.<br>(vi) Quarterly review.<br>(vii) A subset of items upon a resident's transfer, | F 640 | F640<br><br>1. Residents #216, 217, 218, 219, 220, 221, 222, 223 and 224's discharge MDS submissions were reviewed on 10/9/19 and resubmitted. A confirmation report was obtained 10/9/19.<br><br>2. All residents who require discharge MDS submissions to CMS have the potential to be affected. A CMS Missing OBRA report was pulled by our MDS Coordinator for the last 4 years and all other discharge MDS submissions were verified as complete. No other residents were affected.<br><br>3. MDS transmission reports will be monitored weekly by MDS Coordinator for errors and rejections. Any errors and rejections will be investigated and resolved. Our MDS staff were inserviced on 10/28/19.<br><br>4. The Missing OBRA assessment reports will be reviewed weekly by the QAPI committee to ensure all assessments have been submitted. Results will be reviewed weekly by the QAPI committee for a minimum of 90 days. Non-compliance will be addressed through further education and/or disciplinary action as appropriate.<br><br>5. Our corrective action plan will be in place by 11/8/19. | |

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| F 640 | Continued From page 13 | F 640 | | |

reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
Based on a facility document, clinical record reviews and staff interviews, the facility staff failed to encode and/or electronically transmit discharge Minimum Data Set (MDS) assessments to the Centers for Medicare/Medicaid System, for 9 of 48 residents in the survey sample, Resident #216, #217, #218, #219, #220, #221, #222, #223, & #224).

The findings include:

Review of the MDS 3.0 Missing Omnibus Budget Reconciliation Act (OBRA) Assessment report obtained by the facility's staff from the CMS website revealed no MDS OBRA assessments and/or MDS Discharge Assessment had been submitted for the following residents in greater than 92 days.

Resident #216 was admitted to the facility 5/25/18, and was discharged from the facility with return not anticipated 7/3/18. The last assessment accepted into the MDS databank was dated 6/1/18. An interview was conducted with the MDS Coordinator on 10/10/19, at approximately 10 a.m., she stated the resident's discharge MDS was completed and transmitted

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| F 640 | Continued From page 14<br>to CMS 7/9/18, but CMS rejected the MDS. The MDS Coordinator further stated the discharge MDS wasn't corrected, resubmitted and accepted by CMS until 10/10/19.<br><br>Resident #217 was admitted to the facility 7/24/18, and was discharged 7/26/18, with return anticipated. The last assessment accepted into the MDS databank was dated 7/24/18. An interview was conducted with the MDS Coordinator on 10/10/19, at approximately 10 a.m., she stated the resident's discharge MDS was completed and transmitted to CMS but CMS rejected the MDS. The MDS Coordinator further stated the discharge MDS wasn't corrected, resubmitted and accepted by CMS until 10/10/19.<br><br>Resident #218 was admitted to the facility 6/11/18, and was discharged 6/29/18, with return anticipated The last assessment accepted into the MDS databank was dated 6/20/18. An interview was conducted with the MDS Coordinator on 10/10/19, at approximately 10 a.m., she stated the resident's discharge MDS was completed and transmitted to CMS 7/9/18, but CMS rejected the MDS. The MDS Coordinator further stated the discharge MDS wasn't corrected, resubmitted and accepted by CMS until 10/10/19.<br><br>Resident #219 was admitted to the facility 8/15/18, and was discharged 8/18/18, with return not anticipated. The last assessment accepted into the MDS databank was dated 8/15/18. An interview was conducted with the MDS Coordinator on 10/10/19, at approximately 10 a.m., she stated the resident's discharge MDS was completed and transmitted to CMS 8/28/18, but CMS rejected the MDS. The MDS | F 640 | | |

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| F 640 | Continued From page 15<br>Coordinator further stated the discharge MDS wasn't corrected, resubmitted and accepted by CMS until 10/10/19.<br><br>Resident #220 was admitted to the facility 5/25/18, and was discharged 5/27/18, with return not anticipated. The last assessment accepted into the MDS databank was dated 5/25/18. An interview was conducted with the MDS Coordinator on 10/10/19, at approximately 10 a.m., she stated the resident's discharge MDS was completed and transmitted to CMS 6/18/18, but CMS rejected the MDS. The MDS Coordinator further stated the discharge MDS wasn't corrected, resubmitted and accepted by CMS until 10/10/19.<br><br>Resident #221 was admitted to the facility 5/30/18, and was discharged 6/29/18, with return not anticipated. The last assessment accepted into the MDS databank was dated 6/6/18. An interview was conducted with the MDS Coordinator on 10/10/19, at approximately 10 a.m., she stated the resident's discharge MDS was not completed, transmitted and submitted to CMS until 10/10/19.<br><br>Resident #222 was admitted to the facility 1/29/18, and was discharged 2/15/18, with return not anticipated. The last assessment accepted into the MDS databank was dated 2/5/18. An interview was conducted with the MDS Coordinator on 10/10/19, at approximately 10 a.m., she stated the resident's discharge MDS was not completed, transmitted and submitted to CMS until 10/10/19.<br><br>Resident #223 was admitted to the facility 6/9/18, and was discharged 6/30/18, with return not | F 640 | | |

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| F 640 | Continued From page 16<br>anticipated. The last assessment accepted into the MDS databank was dated 6/15/18. An interview was conducted with the MDS Coordinator on 10/10/19, at approximately 10 a.m., she stated the resident's discharge MDS was not completed, transmitted and submitted to CMS until 10/10/19.<br><br>Resident #224 was admitted to the facility 1/25/18, and was discharged 2/9/18, with return not anticipated. The last assessment accepted into the MDS databank was dated 2/1/18. An interview was conducted with the MDS Coordinator on 10/10/19, at approximately 10 a.m., she stated the resident's discharge MDS was not completed, transmitted and submitted to CMS until 10/10/19.<br><br>On 10/10/19, at approximately 3:30 p.m., the above findings were shared with the Administrator and Director of Nursing. The Administrator stated in-servicing on MDS assessments had been set-up for next week. | F 640 | | |
| F 645 SS=D | PASARR Screening for MD & ID<br>CFR(s): 483.20(k)(1)-(3)<br><br>§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.<br><br>§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:<br>(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, | F 645 | F645<br><br>1. A PASRR was immediately completed on resident #95 on 10/10/19. The resident did not experience any adverse outcomes.<br><br>2. All residents admitted to the facility have the potential to be affected. An audit was completed for current residents and PASRR completed per new policy.<br><br>3. A new "Preadmission Screening and Resident Review (PASRR) policy was created on 10/28/19. PASRRs will be completed prior to acceptance to the facility and the form will be scanned into the medical record. Social services, admissions and administrative staff were inserviced on the PASRR policy on 10/28/19. | |

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| F 645 | Continued From page 17<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services; or<br>(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.<br><br>§483.20(k)(2) Exceptions. For purposes of this section-<br>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.<br>(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-<br>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,<br>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and<br>(C) Whose attending physician has certified, | F 645 | 4. Social Services department will randomly audit 5 new admissions monthly to ensure the PASRRs have been completed prior to admission and scanned into the medical record. Results of the audit will be reviewed monthly for a minimum of 90 days by Administrator. Non-compliance will be addressed through further education and/or disciplinary action as appropriate.<br><br>5. Our corrective action plan will be in place by 11/8/19. | |

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| F 645 | Continued From page 18<br>before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.<br><br>§483.20(k)(3) Definition. For purposes of this section-<br>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).<br>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, facility documentation review and clinical record review the facility staff failed to ensure a level I PASRR (Preadmission Screening and Resident Review) screening was completed prior to admission for 1 of 48 residents in the survey sample, Resident #95.<br><br>The findings included:<br><br>Resident #95 was originally admitted to the facility on 01/03/18 and readmitted on 09/11/2019 with diagnoses to include but not limited to, Anxiety Disorder, Major Depressive Disorder and Bipolar Disorder.<br><br>The most recent Minimum Data Set (MDS) assessment was a quarterly dated 08/21/19 which coded the resident with having short-term and long-term memory problems and the resident's cognitive skills for decision making moderately impaired.<br><br>In Section A1500-Preadmission Screening and | F 645 | | |

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| F 645 | Continued From page 19<br>Resident Review, it was not coded.<br><br>On 10/10/19 at approximately 2:18 PM an interview was conducted with the Admissions Director (Other Staff #10). She was asked for a copy of Resident #95's Level 1 PASRR screening. She stated, "We don't have the PASRR." "I'm going to do a QA (Quality Assurance) on that." She was asked if the facility had a PASRR Policy? She stated, "I'll check."<br><br>On 10/10/19 at approximately, 4:47 PM the Administrator was asked if they have a policy on PASRR. She stated, "No."<br><br>On 10/11/19 at approximately 5:15 p.m. a pre-exit interview was conducted with the Administrator concerning the above resident. No further information was provided by the facility staff. | F 645 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interview, and facility documentation review, the facility staff failed to follow professional standards of quality for 1 (Resident #95) of 48 residents in the survey sample. The facility staff failed to follow physician orders by administering oxygen without a Physician's order.<br><br>The findings include: | F 658 | F 658<br><br>1. Resident #95 was assessed and orders were reviewed on 10/10/19. A physician's order was obtained to administer oxygen on 10/10/19. The resident has not had any adverse outcomes.<br><br>2. All residents who require oxygen have the potential to be affected. An audit was conducted on 10/14/19 by DON and Unit Managers and all residents utilizing oxygen were verified as having current oxygen orders. No other residents were affected.<br><br>3. The facility policy "Oxygen Administration" was reviewed and updated as necessary. Licensed nurses will be required to obtain oxygen orders for residents requiring oxygen. Licensed nurses were | |

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| F 658 | Continued From page 20<br><br>Resident #95 was originally admitted to the facility on 01/03/18 and readmitted on 09/11/2019. Diagnoses for Resident #95 included but not limited to Anxiety Disorder, Major Depressive Disorder and Bipolar Disorder.<br><br>The most recent Minimum Data Set (MDS) assessment was a quarterly dated 08/21/19 and coded the resident with having short-term and long-term memory problems and cognitive skills for decision making moderately impaired. Section O, Special Treatments and Programs, 0100C, Respiratory Treatments, on the MDS was not coded for Resident #95 receiving oxygen.<br><br>A review of the MAR (Medication Administration Record) for the month of October, 2019 revealed no oxygen orders where included.<br><br>On 10/08/19 12:58 PM, Resident #95 was observed resting quietly in bed. Resident #95 was receiving oxygen at 2 liters per minute via nasal cannula.<br><br>On 10/09/19 12:00 PM the Resident was observed resting comfortably in bed. Resident #95 was receiving oxygen at 2 liters per minute via nasal cannula.<br><br>On 10/10/19 at approximately, 11:20 AM an interview was conducted with Licensed Practical Nurse (LPN) #5 concerning oxygen verification. He was asked to verify if Resident #95 was receiving oxygen and the amount. Resident #95 was resting quietly as LPN #5 entered the room. He verified that resident was receiving oxygen at 2 liters via nasal cannula. | F 658 | inserviced on the Oxygen Administration policy.<br><br>4. The Central Supply Clerk will conduct weekly checks on all residents utilizing oxygen and submit to Nursing Administration to ensure proper oxygen orders are in place. Results will be reviewed weekly by QAPI committee for a minimum of 90 days. Non-compliance will be addressed through further education and/or disciplinary action as appropriate.<br><br>5. Our corrective action plan will be in place by 11/8/19. | |

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| F 658 | Continued From page 21<br>A review of the physician order summary conducted on 10/09/19 listed no oxygen orders for Resident #95.<br><br>On 10/10/19 at approximately 2:35 PM an interview was conducted with the Clinical Manager, LPN #6 concerning oxygen orders for Resident #95. She stated, "There were no orders written."<br><br>On 10/1019 at approximately 2:56 PM an interview was conducted with LPN #5. He was asked what should have been done concerning Resident #95 oxygen order. LPN #5 stated, "I should have notified the doctor to make sure the order was put in when resident came in for re-admission."<br><br>On 10/11/19 at approximately 5:15 PM a pre-exit interview was conducted. The Administrator was informed of the findings. | F 658 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and clinical record review the facility staff failed to ensure 1 of 48 residents (Resident #33) in the survey sample who were unable to carry out activities of daily living (ADL) received the necessary services to maintain fingernail care.<br><br>The findings included: | F 677 | F677<br><br>1. Resident #33's nails were trimmed on 10/9/19. There were no signs of infection or injury.<br><br>2. All residents have the potential to be affected. An audit on all resident's nails was conducted and no other residents were affected.<br><br>3. Nursing staff was inserviced on the Nail Care Policy. Unit Managers will conduct skin assessments to include nail care during their quarterly assessments.<br><br>4. DON or designee will conduct monthly compliance audits and results will be reviewed monthly by the QAPI committee | |

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| BETH SHOLOM HOME OF EASTERN VI | 6401 AUBURN DR VIRGINIA BEACH, VA 23464 |

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| F 677 | Continued From page 22<br><br>The facility staff failed to ensure that fingernail care was provided to Resident #33.<br><br>Resident #33 was originally admitted to the facility on 02/24/12. Diagnosis for Resident #33 included but not limited to Anxiety and Depression. The current Minimum Data Set (MDS), an annual assessment with an Assessment Reference Date (ARD) of 06/19/19, coded Resident #33 with a 05 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. In addition, the MDS coded Resident #33 requiring total dependence of one with bathing and limited assistance of one with hygiene.<br><br>Resident #33's comprehensive care plan with a revision date of 11/04/19, under loss of ADL function, included decreased ability to complete ADL's without assistance related to history of compression fracture to spine, pain, depression, anxiety, decreased mobility, poor cognition and decreased vision. The goal: will have needs met by staff during the next period to promote optimal level of comfort. The interventions included but not limited to: assist with ADL's as needed.<br><br>During the initial tour of the facility on 10/08/19 at approximately 11:43 a.m., Resident #33 was observed lying bed with her hands placed outside of the covers. Resident #33's fingernails were observed to be long with jagged edges and brown substance under her fingernails. On the same day at approximately 3:23 p.m., Resident #33's fingernails remained unchanged.<br><br>On 10/09/19 at approximately 10:08 a.m., | F 677 | for a minimum of 90 days. Non-compliance will be addressed through further education and/or disciplinary action as appropriate.<br><br>5. Our corrective action plan will be in place by 11/8/19. | |

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| F 677 | Continued From page 23 | F 677 | | |

Resident #33's fingernails remains unchanged. On the same day at approximately 1:17 p.m., License Practical Nurse (LPN) #1 assessed Resident #33's fingernails with the surveyor present. The LPN stated, "Yes, her fingernails need to be cut and trimmed; I'll take care of it today." The surveyor asked, "When do the staff trim and cut the resident's fingernails?" She replied, "As needed and when their fingernails are long and sharp." The LPN said the Certified Nursing Assistants (CNA's) should be assessing the resident fingernails daily during ADL care and on their shower days. The shower assignment on the Blue Unit scheduled Resident #33 to receive her showers every Monday and Thursday, 11-7 shift.

On 10/10/19 at approximately 11:50 p.m., Resident #33 was observed with her fingernails cut, trimmed and clean.

A briefing was held with the Chief Executive Officer (CEO) and Administrator on 10/10/19 at approximately 4:25 p.m. The facility did not present any further information about the findings.

The facility's policy titled Activities of daily Living (ADLs), Supporting (revision: March 28, 2019).
-Policy statement: Residents will provided with care, treatment and services as services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's).

-Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and oral hygiene.

Policy Interpretation and Implementation include

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| F 677 | Continued From page 24<br>but not limited to:<br>2. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care). | F 677 | | |
| F 687 SS=D | Complaint deficiency<br>Foot Care<br>CFR(s): 483.25(b)(2)(i)(ii)<br><br>§483.25(b)(2) Foot care.<br>To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:<br>(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and<br>(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews, clinical record review,and in the course of a complaint investigation, the facility staff failed to ensure 1 of 48 residents (Resident #44) in the survey sample who were unable to carry out activities of daily living, received the necessary services for toenail care.<br><br>The findings included:<br><br>The facility staff failed to ensure that podiatry services was provided to Resident #44. | F 687 | F687<br><br>1. Resident #44 was evaluated by a medical provider on 1/14/19 and treated for ingrown left great toenail with onchomycosis/dystrophic nails. She was also seen by a podiatrist the same day with no infection found. She continues to be seen on a quarterly basis.<br><br>2. All residents who require podiatry services have the potential to be affected. Licensed nurses conducted an audit on all residents on 1/14/19. Any residents found to need podiatry services were referred to either the in-house or off-site podiatrist for foot care.<br><br>3. The facility policy for "Nail Care" was reviewed and updated. Podiatry appointment books were implemented and unit secretaries are responsible for scheduling and tracking all podiatry appointments. A quarterly skin assessment was created and implemented and Unit Managers complete skin assessments with focus on podiatry needs on a quarterly basis. Staff was inserviced on the process and their roles and responsibilities by the Staff Development Coordinator or designee by the compliance date. | |

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| F 687 | Continued From page 25<br><br>Resident #44's Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date of 07/17/19 coded Resident #44's Brief Interview for Mental Status (BIMS) score of 00 out of a possible score of 15 indicating severe cognitive impairment. In addition, the MDS coded Resident #44 total dependence of two with transfer, toilet dependence of one with dressing, hygiene and bathing, extensive assistance of two with bed mobility and toilet use and extensive assistance of one with eating for Activities of Daily Living (ADL) care.<br><br>Resident #44's comprehensive care plan with a revision date of 01/14/19 documented resident with Onychomycosis toenails. The goal: decreased risk for complications from onychomycosis (nail fungus). Some of the intervention/approaches to manage goal included: follow up with podiatrist as indicated, monitor/report need for changes in treatment, medicate for discomfort as needed and monitor/report sign/symptoms of infection.<br><br>On 10/08/19 at approximately 2:12 p.m., Resident #44 was observed sitting up in geri chair in the day lounge. Resident #44's fingernails were cut short, trimmed and cleaned.<br><br>An interview was conducted with Chief Executive Officer (CEO) on 10/10/19 at approximately 11:40 a.m., who stated, "I had a phone conversation with Resident #44's son related to having an issue with one toenail but nothing about her fingernails." The CEO said he spoke with the Administrator and nursing and the issue was taken care. The CEO said a podiatry | F 687 | 4. Unit Managers conducted assessments/audits on 2 residents from each unit weekly for 4 weeks; then every 2 weeks for 8 weeks. Results were reviewed and tracked and trended weekly during QAPI meetings with 100% compliance noted. Non-compliance will be address through further education and/or disciplinary action as appropriate.<br><br>5. Our corrective action plan was put in place on 1/14/19 and successfully completed on 4/5/19. | |

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| F 687 | Continued From page 26<br>appointment was made and Resident #44 was seen right away.<br><br>On 01/14/19, according to the facility documentation, on 01/12/19, Resident #44's left great toe was reddened and painful to touch. The physician was notified, and order received to start *Keflex 500 mg daily for 5 days and to start bacitracin (antibiotic) ointment to the left great toe until healed. An order also received to make an appointment on Monday, 1/14/19, with the podiatrist.<br><br>On 1/14/19, according to the facility's documentation, Resident #44 returned from her podiatry appointment; toenails trimmed with no new orders. Resident denied pain or discomfort. Review of consultation report from the podiatrist visit on 01/14/19 included the following:<br><br>-Findings: Elongated and loose from nail bed with subungual debris. No signs of infection.<br>-Diagnosis: Tina Unguium.<br><br>Definition:<br>-Tina unguium is the most common fungus infection of the nails, also called onychomycosis. Onychomycosis makes the nails look white and opaque, thickened and brittle (www.medicineNet.com).<br><br>On 10/09/19 at approximately 9:43 a.m., Certified Nursing Assistant (CNA) #1 and this surveyor went to Resident #44's room. The CNA removed Resident #44's socks from both feet. The resident's toenails were short, trimmed, clean and without redness or swelling.<br><br>An interview was conducted with the Clinical | F 687 | | |

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| F 687 | Continued From page 27<br>Manager on Blue Unit on 10/10/19 at approximately 2:00 p.m. She stated, "I do remember Resident #44 having an issue with her left great toe." The clinical manager said Resident #44's left great toe was elongated, red and swollen. The Clinical Manager said the CNA's should be checking the resident's fingernail and toenails daily while providing ADL care and the nurses when performing the weekly skin assessments.<br><br>Review of Resident #44's Nursing-Weekly Summary/Clinical Documentation Report completed on 01/11/19 included the following under section 2: inspect entire body from head to toe. Note any abnormalities or skin breakdown on figures below. Any new areas of skin breakdown must be accompanied by new treatment as appropriate. The nurse documented skin intact. The Licensed Practical Nurse (LPN) who completed the assessment is no longer employed at the facility.<br><br>An interview was conducted with the Director of Nursing (DON) on 10/10/19 at approximately 2:24 p.m. The surveyor requested the last podiatry visit prior to 01/14/19. On the same day at approximately 2:31 p.m., the DON stated, "This is the last podiatry visit found in Resident #44's clinical record." The DON presented a consultation report showing evidence that Resident #44 was last seen by the podiatrist on 08/16/17. The surveyor asked, "How often should a resident receive podiatry services" she replied, "At least every 2-3 months."<br><br>A briefing was held with the Chief Executive Officer (CEO) and Administrator on 10/10/19 at approximately 4:25 p.m. The facility did not | F 687 | | |

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| F 687 | Continued From page 28<br>present any further information about the findings.<br><br>The facility's policy titled Activities of daily Living (ADLs), Supporting (revision: March 28, 2019).<br>-Policy statement: Residents will provided with care, treatment and services as services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's).<br><br>-Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and oral hygiene.<br><br>Policy Interpretation and Implementation include but not limited to:<br>2. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care).<br><br>Definitions:<br>Keflex is an antibiotic. It works by fighting bacteria in your body. Keflex is used to treat infections caused by bacteria, including upper respiratory infections, ear infections, skin infections, urinary tract infections, and bone infections. | F 687 | | |
| F 688 SS=D | Complaint deficiency<br>Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in | F 688 | F688<br>1. Resident #60 was assessed and orders were reviewed on 10/10/19. A physician's order was obtained on 10/10/19 for a therapy evaluation and for bilateral hand splints: a new physician order was obtained 10/11/19 to apply resting splints to bilateral hands, during the day upon | |

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| F 688 | Continued From page 29<br>range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident interview, staff interview, and clinical record review the facility's staff failed to obtain a physician's order prior to applying bilateral arm/hand splints for 1 of 48 residents (Resident #60), in the survey sample.<br><br>The findings included:<br><br>Resident #60 was originally admitted to the facility 10/28/18 and has never been discharged from the facility. The current diagnoses included; polyosteoarthritis with stiffness of the elbows and pain to bilateral hands.<br><br>The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/7/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 8 out of a possible 15. This indicated Resident #60 cognitive abilities for daily decision making were moderately impaired. In section "G" (physical functioning) the resident was coded as requiring extensive assistance of one person with | F 688 | resident's request for no longer than 6 hours at a time and every eveing for 3-6 hours. The resident has not had any adverse outcomes.<br><br>2. All residents who require splint devices have the potential to be affected. A 100% audit of residents requiring splint devices was conducted by DON and Unit Managers on 10/14/19 and no other residents were affected.<br><br>3. The facility policy for "Resident Mobility and Range of Motion" was reviewed and updated. DON/Unit Managers will complete weekly audits on splint/brace use and orders and report in Standards of Care. Staff was inserviced on the process and their roles and responsibilities by the Staff Development Coordinator or designee by the compliance date.<br><br>4. Unit Managers will do a weekly audits of all resident's requiring splints/braces to ensure physician orders are in place.<br><br>5. Our corrective action plan will be in place by 11/8/19. | |

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| F 688 | Continued From page 30<br>bed mobility and personal hygiene, total care of two with transfers and toileting, and total care of two with locomotion, dressing, eating, and bathing.<br><br>Resident #60 was observed in her room having lunch 10/8/19 at approximately 12:30 p.m., she stated she wears the arm/hand splints observed on her dresser overnight only and the staff removes them before breakfast so she can use her hands during the day to feed herself, dial the phone, answer the phone, etc.<br><br>Resident #60's was observed on 10/26/19 at approximately 1:10 p.m., and the arm/hands splints were on her bedside table. The resident again stated she doesn't wear arm/hand splints during the day because they would prevent her from using her hands.<br><br>Review of Resident #60's physician orders revealed no order for use of bilateral hand/arm splints.<br><br>An interview was conducted with Assistant Director of Nursing (ADON) on 10/10/19 at approximately 2:00 p.m., she stated after reviewing the resident's orders they noticed there was no order and likely the staff was applying and removing the splints based on what the resident stated. The ADON further stated at the time of Resident #60's admission there was an order for the arm/hand splints but they failed to transcribe it. The original order the resident transferred to the facility with read: Resident should wear bilateral splints 2-4 hours daily (one at a time) from 7:00 a.m., to 7:00 p.m. The ADON stated since learning there was no current order, an order was obtained for Occupational Therapy to | F 688 | | |

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| F 688 | Continued From page 31<br>assess the resident for appropriateness and to determine a wearing schedule if the splints use should be continued.<br><br>On 10/10/19, at approximately 3:30 p.m., the above findings were shared with the Administrator and Director of Nursing. An opportunity was given for the facility to present additional information but none was provided. | F 688 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced | F 761 | F761<br><br>1. No residents were affected as a result of the failure to keep a medication cart locked and under direct observation of authorized staff. One on one education was provided to the involved nurse.<br><br>2. All residents have the potential to be affected. The ADON conducted an audit on 10/9/19 to ensure all med carts were locked when not directly supervised and all were in compliance.<br><br>3. "Security of Medication Cart" policy was reviewed. Licensed nursing staff was educated on locking medication carts when not under direct supervision.<br><br>4. Weekly spot checks will be conducted by Staff Development Coordinator and reported weekly during Standards of Care. Results will be reviewed weekly by the QAPI committee for a minimum of 90 days. Non-compliance will be addressed through further education and/or disciplinary action as appropriate.<br><br>5.Our corrective action plan will be in place by 11/8/19. | |

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| F 761 | Continued From page 32<br>by:<br>Based on observations, staff interviews and facility documentation review the facility staff failed to ensure 1 of 8 medication carts (Gifford Unit) was kept locked or under direct observation of authorized staff in an area where residents could access it; and failed to remove expired biological's from 1 of 3 Medication Storage Rooms (Sholom Unit).<br><br>The findings included:<br><br>1. On 10/08/2019 at 12:45 p.m., the Surveyor observed Licensed Practical Nurse (LPN) #4 prepare medications while standing in front of the medication cart in the hallway outside of room 109. The LPN and Surveyor walked into room 109; the medication cart was left unlocked. The LPN closed the door to room 109.<br><br>On 10/08/2019 at approximately 1:00 p.m., an interview was conducted with LPN #4. The above observation was reviewed with LPN #4 and she was asked, "Should you have left the medication cart unlocked and unsupervised when you went into room 109 and closed the door?" LPN #4 stated, "No, I should have locked the cart. I guess I'm nervous. I don't usually leave it unlocked."<br><br>On 10/08/2019 at 4:30 p.m., a copy of the Medication Storage Policy was requested.<br><br>On 10/09/2019 at approximately 9:00 a.m., a copy of the facility policy, titled Storage of Medications, was received and reviewed:<br><br>Policy Statement: The facility shall store all drugs and biological's in a safe, secure, and orderly | F 761 | Expired biologicals<br><br>1. No residents were afftected as a result of failure to remove expired biologicals from the medication room. The expired biologicals were immediately disposed of by the Unit Manager and were reordered on 10/8/19.<br><br>2. All residents requiring the use of biologicals have the potential to be affected. All med rooms were checked and no further expired biologicals were found.<br><br>3. The policy "Storage of Medications and Biologicals" was reviewed and updated. Lab supplies will be kept in one cabinet in each med room. Expiration dates will be checked weekly and logged by Central Supply Clerk. Licensed nursing staff and Central Supply Clerk will be inserviced on the policy.<br><br>4. Weekly spot checks will be conducted by Unit Managers and results will be reviewed weekly by the QAPI committee for a minimum of 90 days. Non-compliance will be addressed through further education and/or disciplinary action as appropriated.<br><br>5. Our corrective action plan will be in place by 11/8/19. | |

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| F 761 | Continued From page 33 | F 761 | | |

manner.
Policy Interpretation and Implementation: The facility shall not use discontinued, outdated, or deteriorated drugs or biological's. All such drugs shall be returned to the dispensing pharmacy or destroyed.

The Director of Nursing was made aware of the finding during a briefing on 10/09/2019 at 5:35 p.m. The Director of Nursing was asked, "What are your expectations of the nurse when the medication cart is out of their sight?" The Director of Nursing stated, "When the cart is out of their sight it should be locked." No further information was provided.

2. On 10/08/2019 at 11:30 a.m., this Surveyor inspected the Medication Storage Room on the "Sholom Unit" with Licensed Practical Nurse (LPN) #5 and observed BBL CultureSwab - Collection and Transport Systems with a expiration date of 09/30/2019. LPN #5 was asked to look at the BBL CultureSwab package and he was asked, "What do you see on the package?" LPN #5 stated, "It is expired." The Surveyor asked LPN #5, "How many BBL CultureSwabs are expired?" LPN #5 stated, "There are 15 swabs that are expired. They should have been checked." LPN #5 removed the CultureSwabs from the Medication Storage Room. LPN #5 stated, "I will notify the Supervisor and contact the lab for more to be sent."

The Director of Nursing was made aware of the finding during a briefing on 10/09/2019 at 5:35 p.m. The Director of Nursing was asked, "What are your expectations of nurses and the monitoring of biological's?" The Director of Nursing stated, "The nurses do rounds for

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| F 761 | Continued From page 34<br>Infection Control and biological's and the Unit Managers are to check their Medication Storage Rooms weekly. Expectations are that the Unit Manager will check med rooms for expired biological's." No further information was provided. | F 761 | | |
| F 810 SS=D | Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g)<br><br>§483.60(g) Assistive devices<br>The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident interview, staff interview, and clinical record review the facility's staff failed to provide a handled cup at meal times for 1 of 48 residents (Resident #60), in the survey sample.<br><br>The findings included:<br><br>Resident #60 was originally admitted to the facility 10/28/18 and has never been discharged from the facility. The current diagnoses included: polyosteoarthritis with stiffness of the elbows and pain to bilateral hands.<br><br>The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/7/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 8 out of a possible 15. This indicated Resident #60 cognitive abilities for daily decision making were moderately impaired. In section "G" | F 810 | F810<br>1. Resident #60 was assessed and her chart was reviewed. The resident has not had any adverse effects evidenced by no liquid spills. The order for the two handled mug was changed from "may use" to "provide resident with two handled safety mug at all meals" to ensure compliance.<br><br>2. All residents who require assistive eating devices have the potential to be affected. Chart audits were completed on all residents with orders for assistive eating devices to validate accuracy. No other residents who have specialized eating and drinking utensils were affected by the deficient practice. The food service director moved the assistive devices utilized to the top of the tray ticket from the bottom for quicker visualization.<br><br>3. Dietary staff was educated on the movement of the assistive devices utilized from the bottom to the top of the meal tickets for quicker visualization. The Assistive Eating Device policy was reviewed and updated.<br><br>4. The food service director and restorative CNA will each conduct (3) meal spot checks for compliance with assistive eating devices and findings will be reviewed weekly during Standard of Care meetings. Non-compliance will be addressed through further education and/or disciplinary action as appropriate. | |

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| F 810 | Continued From page 35<br>(Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility and personal hygiene, total care of two with transfers and toileting, and total care of two with locomotion, dressing, eating, and bathing.<br><br>Resident #60 was observed in her room having lunch 10/8/19 at approximately 12:30 p.m., she stated "They are not sending my handled cup on the trays; I need it because I can hold it better. These containers are too large for me to grip."<br><br>Resident #60's tray was observed 10/8/19 at approximately 1:10 p.m., the resident stated they still aren't sending my handled cup. The resident also stated the cup is clear in color, has a top and handles I can easily grasp and hold.<br><br>Review of Resident #60's physician orders revealed an order dated 10/7/19 which read; Regular consistency, Regular special, pre-cut meats, Provide raised lip plate for all meals, built up utensils, May use a two handled safety cup.<br><br>Review of Resident #60's care plan dated 10/26/18 revealed the following intervention; provide assistive devices; pre-cup meats, raised lip plate for all meals and built up utensils. A care plan note dated 9/20/19, read; chart audit completed meal ticket matched; regular diet, cut up meats, raised lip plate, weighted utensils and other personal preferences.<br><br>An interview was conducted with the Food Service Manager on 10/10/19, at approximately 2:40 p.m. The Food Service Manager stated the resident should have a handled cup (a personal preference) on her trays and he addressed the | F 810 | 5. Our corrective action plan will be in place by 11/8/19. | |

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| F 810 | Continued From page 36<br>concern with the staff. He stated their response was it was an oversight. The Food Service Manager stated they are meticulous with ensuring the dietary care are accurate and items are color coded to bring attention to the staff of assistive devices and preferences.<br><br>On 10/10/19, at approximately 3:30 p.m., the above findings were shared with the Administrator and Director of Nursing. An opportunity was given for the facility to present additional information but none was provided. | F 810 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility staff failed to ensure that food was | F 812 | F812<br><br>1. No residents were cited or affected as a result of improper food storage and food being kept and served at the wrong temperature.The unlabeled/expired food and the puree quiche were thrown out immediately on 10/8/19.<br><br>2. All residents have the potential to be affected. Food service director did immediate sweep of food storage areas to ensure items were correctly labeled and dated. Director immediately discarded items found to be out of date.<br><br>Food service director inserviced staff on 10/8/19 on the correct way to reheat food in holding area that did not meet proper holding temperatures.<br><br>3. Food services staff was inserviced on proper labeling and dating of food storage. Food service supervisors or designess will conduct daily sign off for cold and hot storage areas for proper labeling. If item is found out of date, it will be immediately removed and discarded. | |

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| F 812 | Continued From page 37<br>prepared, stored and served under sanitary conditions.<br><br>During an inspection of the Facility kitchen occurring 10/08/2019 through 10/10/2019, it was found that the Facility staff:<br>1. Stored unlabeled, expired food in the refrigerator and freezer.<br>2. Kept and served food under the required temperature.<br><br>The findings included:<br><br>During an initial inspection of the facility kitchen on 10/8/2019 at approximately 11:37 a.m., a reading of pureed quiche showed a holding temperature of 111 degrees. Further observation yielded that the quiche was served on trays to be distributed to residents. During an interview with the Dietary Manager on 10/10/2019 at approximately 2:45 p.m., when asked about serving pureed quiche under required temperatures, his response was, "According to our policy, the quiche was served just under the required temperature of 115 degrees."<br><br>During an inspection of the facility dairy kitchen refrigerator on 10/8/2019 at approximately 11:40 a.m., it was noted that the label on an opened bag of bagels showed 9/24/2019. Additionally, an opened jar of grape jelly was not labeled with use by dates. During an interview with the Dietary Manager on 10/10/2019 at approximately 11:21 p.m., when asked about the bagels and grape jelly, he responded, "The bag of bagels had the expiration date of the tab. The jar of grape jelly showed an expiration date of 10/9/2019, so we threw it out." The Facility Dietary Manager was unable to produce the bagels to verify the | F 812 | Food services staff was inserviced on how to properly check food holding temperatures. The production staff will take temperatures of the hot food being served three times during each meal period and record findings on production logs. If items are found out of temperature, the corrective action is to reheat to the appropriate temperature for fifteen seconds, and then return to line of service. Supervisors will spot check for accuracy.<br><br>4. A member of food service management will do random weekly spot checks to ensure the findings are accurate. Findings will be reported on the Standards of Care report. Non-compliance will be addressed through further education and/or disciplinary action as appropriate.<br><br>5. Our corrective action plan will be in place by 11/8/19. | |

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| F 812 | Continued From page 38<br>expiration date upon request.<br><br>An inspection of the facility meat kitchen freezer on 10/8/2019 at approximately 11:45 a.m., yielded, meals frozen in containers, and a bag of frozen, french-fry potatoes that were not labeled with "use-by" expiration dates and a bag of frozen meatballs had a use-by date of 10/4/2019. An interview held with the Dietary Manager on 10/10/2019 at approximately 11:25 a.m., responded, "We threw those out and replaced them with newer meals."<br><br>Facility policies regarding Food Preparation and Service stated the following:<br>Food Preparation Cooking and Holding Temperatures and Times:<br>1. The "danger zone" for food temperatures is between 41 degrees Fahrenheit and 135 degrees Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms that cause food borne illness.<br>3. The longer foods remain in the "danger zone" the greater the risk for growth of harmful pathogens. Therefore, PHF (Potentially Hazardous Foods) must be maintained below 41 degrees Fahrenheit or above 135 degrees Fahrenheit.<br>5. The following internal cooking temperatures/times for specific foods must be reached to kill or sufficiently inactivate pathogenic microorganisms:<br>b. Ground meat, ground fish and eggs held for service - at least 115 degrees Fahrenheit.<br>e. Unpasteurized eggs - until all parts of the egg (yolks and whites) are completely firm (160 degrees Fahrenheit).<br>These findings were reviewed with the Facility Administrator during a meeting on 10/10/2019 at | F 812 | | |

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| F 812 | Continued From page 39<br>3:19 p.m. | F 812 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions | F 880 | F 880<br><br>1. Resident #342 did not experience any adverse outcomes as a result of the nurse not performing proper hand hygiene after removing dirty gloves. The nurse received one on one re-education and was required to demonstrate the appropriate technique.<br><br>2. All resident who receive glucoscan and insulin have a potential to be affected. Nursing administration conducted observations on 10/14/19 of scheduled nurses and proper hand hygiene was observed and no other residents were affected.<br><br>3. The facility policy "Handwashing/Hand Hygiene" was reviewed and no revisions were necessary. Nursing staff will be inserviced on the policy and procedure by Staff Development Coordinator or designee by the compliance date.<br><br>4. Licensed nursing staff will be responsible to perform proper hand hygiene. Weekly spot checks will be conducted by Staff Development Coordinator and results will be reviewed weekly by the QAPI committee for a minimum of 90 days. Non-compliance will be addressed through further education and/or disciplinary action as appropriate.<br><br>5. Our corrective action plan will be in place by 11/8/19. | |

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| F 880 | Continued From page 40<br>to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and facility documentation review the facility staff failed to have a water management plan for the facility; and failed to perform appropriate hand hygiene after removing dirty gloves for 1 of 48 residents in the survey sample (Resident #342).<br><br>The findings included: | F 880 | Water Management Plan<br><br>1. No residents were adversely affected as a result of the facility not having documentation of a water management plan. Beth Sholom contracts with Nalco to manage the testing of the water and maintain the water management program. The facility contacted Theresa Danbusky with Nalco Water to develop a written policy and procedure on 10/10/19.<br><br>2. All residents residing in the facility have the potential to be affected by the facility not having a water management policy and procedure in place.<br><br>3. A water management program has been developed by Nalco Water, an Ecolab company. The program specifies the standard of care required for all locations of site management of Beth Sholom for water safety management. Included in this program is Legionella culture testing, as well as a 10 point water safety and At Risk Water System inspection by Nalco. This testing will be conducted annually. The new water management policy has been added to our electronic preventative maintenance program for annual review by Nalco and the Maintenance Director.<br><br>4. The results of the Nalco's annual findings of the At Risk Water System Inspection, Legionella, as well as 10 point water safety inspection will be reviewed during a QAPI meeting annually.<br><br>5. Our corrective action plan will be in place by 11/8/19. | |

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| F 880 | Continued From page 41<br><br>1. On 10/08/2019 at approximately 3:00 p.m., an interview was conducted with the Maintenance Director and he was asked for the facility's Legionella protocol. The Maintenance Director stated, "We don't do any testing for Legionella. We do not have a problem with Legionella because we have a closed loop system, chiller system, and it is chemically treated."<br><br>On 10/09/2019 at approximately 11:30 p.m., the facility risk assessment was reviewed and revealed the "Probability of Water Contamination" was scored as low.<br><br>On 10/09/2019 at 12:55 p.m., an interview was conducted with the Maintenance Director and he was asked, "Do you have a water management policy and procedure?" The Maintenance Director stated, "No, we do not." The Maintenance Director was asked, "Do you have any water testing protocols to test for potential pathogens in the water?" The Maintenance Director stated, "We have a company that comes out every three months."<br><br>During a briefing on 10/09/2019 at 2:20 p.m., the Administrator was asked, "Do you have a water management plan for the facility?" The Administrator stated, "No, but I will tomorrow." The Administrator was asked, "Should you have already had a water management plan?" The Administrator stated, "Yes." The Maintenance Director asked, "Is this something new?" The Administrator stated, "No." No further information was provided.<br><br>2. On 10/08/2019 at 12:45 p.m., the Surveyor observed Licensed Practical Nurse (LPN) #4 | F 880 | | |

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| F 880 | Continued From page 42<br>apply clean gloves and remove a glucometer and blood testing supplies from the medication cart. LPN #4 and the Surveyor entered Resident # 342's room and LPN #4 obtained a blood sugar sample and checked the resident's blood sample with the glucometer. LPN #4 returned to the medication cart with the glucometer and removed a Micro-Kill wipe from the container and cleaned the glucometer. LPN #4 removed her dirty gloves and applied clean gloves. LPN #4 failed to perform hand hygiene after removing her dirty gloves. LPN #4 drew up insulin into a syringe and went back to into Resident #342 room and administered the insulin to Resident #342. LPN #4 then went back to the medication cart, disposed of the insulin syringe, removed her dirty gloves and performed hand hygiene with hand sanitizer.<br><br>On 10/08/2019 at approximately 1:00 p.m., an interview was conducted with LPN #4 and she was asked, "Should you have performed hand hygiene after you removed your dirty gloves and before applying the clean gloves?" LPN #4 stated "Yes I should have."<br><br>On 10/08/2019 at 4:30 p.m., policy on hand hygiene was requested.<br><br>On 10/09/2019 at approximately 9:00 a.m., a copy of the facility policy, Handwashing / Hand Hygiene, was received and included:<br><br>Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infection.<br>Policy Interpretation and Implementation: Use an alcohol - based hand rub; or, alternatively, soap (antimicrobial or non-microbial) and water for the | F 880 | | |

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| F 880 | Continued From page 43<br>following situations: After removing gloves.<br><br>The Director of Nursing was made aware of the finding during a briefing on 10/09/2019 at 5:35 p.m. The Director of Nursing was asked, "What are your expectations of nurses and performing hand hygiene?" The Director of Nursing stated, "I expect the nurses to wash their hands or use hand sanitizer when going from clean to dirty." No further information was provided by the facility staff. | F 880 | | |
| F 921 SS=D | Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)<br><br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and facility documentation, the facility staff failed to maintain a safe, clean, comfortable and sanitary environment and for 1 of 48 residents (Resident #43) in the survey sample.<br><br>The finding included:<br><br>The facility staff failed to ensure Resident #43's personal wheel chair was maintained in a sanitary condition. Resident #43 was originally admitted on 01/30/12. Diagnoses for Resident #43 included but not limited to Glaucoma.<br><br>The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 07/17/19 coded Resident #43 with a 15 out of a possible score of 15 on the Brief | F 921 | F921<br><br>1. Resident #43's wheelchair was thoroughly cleaned by Unit Manager.<br><br>2. All residents who require the use of mobility devices have the potential to be affected. Nursing Administration conducted an audit on 10/14/19 of all wheelchairs for cleanliness and no other residents were affected.<br><br>3. The facility policy "Cleaning and Disinfection of Resident Wheelchairs and Gerichairs" was reviewed. Nursing, environmental services and maintenance staff will be inserviced on the process and their roles and responsibilities by the Staff Development Coordinator or designee by the compliance date. A reminder for mobility device cleaning will be placed on CNA assignment sheets.<br><br>4. Nursing staff will be responsible for monitoring the cleanliness of mobility devices daily. Weekly spot checks will be conducted by Staff Development and results will be reviewed weekly by QAPI committee for a minimum of 90 days. Non-compliance will be addressed through further education and/or disciplinary action | |

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| F 921 | Continued From page 44<br>Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #43 requiring extensive assistance of one with transfers. The MDS was coded under section G 0600 for the use of a wheel chair for mobility devices.<br><br>During the initial tour of the facility on 10/08/19 at approximately 12:10 p.m., Resident #43 was observed sitting up in her wheel chair. Her wheel chair was observed with dust, dirt and hair on the both wheels and the metal bar on the back of the wheel chair was covered with a white substance.<br><br>On 10/09/19 at approximately 10:03 a.m., Resident #43 was sitting up in her wheel chair. The wheel chair remained unchanged, observed with dust, dirt and hair on the both wheels and the metal bar on the back of the wheel chair remain covered with a white substance. Resident #43 said her wheel chair has not been cleaned for a while now.<br><br>On 10/09/19 at approximately 1:17 p.m., the Clinical Manager on Blue Unit and surveyor went to Resident #43's room. The surveyor asked, "Does Resident #43's wheel chair need cleaning?" She looked at the wheel chair and replied, "Absolutely, her wheel chair should be clean twice a week on her shower days and as needed." The shower assignment on the Blue Unit scheduled Resident #43 to receive her showers every Tuesday and Friday, 3 PM-11 PM shift.<br><br>A briefing was held with the Chief Executive Officer (CEO) and Administrator on 10/10/19 at approximately 4:25 p.m. The facility did not present any further information about the findings. | F 921 | as appropriate.<br><br>5. Our corrective action plan will be in place by 11/8/19. | |

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| F 921 | Continued From page 45<br><br>The facility's policy titled Cleaning and Disinfection of Resident Wheelchairs and Gerichairs (revised 05/07/18).<br>-Policy Statement: Resident-care equipment, durable medical equipment will be cleaned and disinfected according to current Center for Disease Control (CDC) and the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard.<br><br>Policy Interpretation and Implementation include but not limited to:<br>4. Wheelchairs and gerichairs will be cleaned in the shower room on resident's bath days. Disinfectants will be used for cleaning wheelchairs and gerichairs. If chairs are extremely soiled, environmental services will pressure wash. | F 921 | | |
| F 925 SS=E | Maintains Effective Pest Control Program<br>CFR(s): 483.90(i)(4)<br><br>§483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility staff failed to ensure that food storage, preparation, dining, and conference areas were free of visible signs of flies.<br><br>The findings included:<br><br>During an initial inspection of the kitchen and dining area on 10/8/2019 at approximately 11:37 a.m., flies were observed on covered dishes of peach cobbler and dining room tables. | F 925 | F925<br><br>1. No residents were cited as a result of the failed pest control program. At the time it was brought to the attention of the food service director, our environmental services director contacted our Pest Control Company who in turn came out on 10/8/19 to service all the Fly Equipment.<br><br>2. All resident have the potential to be affected by this finding. Spot checks were conducted throughout the facility. No other areas were affected.<br><br>3. Facility will develop a written plan for monitoring the efficacy of the current equipment. The Pest Control Company will now perform by-weekly service visits. Environmental service director will round daily and check binders daily and notify the Pest Control Company as needed. | |

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| F 925 | Continued From page 46<br>Additionally, flies were observed within the volunteer conference room.<br><br>An interview was conducted on 10/10/2019 at approximately 2:26 p.m. with the Dietary Manager regarding observations of flies in the kitchen, dining area and volunteer conference room. The Dietary Manager responded, "We have a fly deterrent system that uses ultra-violet lights to attract flies. We also have an air curtain at the back door to deter flies. The ultra-violet lights attract the flies and then glue sticks inside the light fixtures, kill them."<br><br>Facility provided Pest Control Policy & Procedure:<br>1. Monitor access to the facility by pests and insects.<br>2. Deny pests food, water, and hiding/nesting places.<br>3. Wet towels and mop heads should be taken to the laundry area at the end of each shift to minimize the risk of infestation by pests.<br>4. A log book of visualized pests will be maintained by the Environmental Services Department. The log will be used by the exterminator to identify areas for targeted treatment and follow up.<br><br>These findings were reviewed with the facility Administrator during a meeting on 10/10/2019 at 3:19 p.m. No further information was provided by the facility staff. | F 925 | 4. Facility environmental services director will monitor the compliance of the Pest Control Plan monthly through audits and will review audit results with the Administrator.<br><br>5. Our corrective action plan will be in place by 11/8/19. | |
| F 948 SS=E | Training for Feeding Assistants<br>CFR(s): 483.95(h)<br><br>§483.95(h) Required training of feeding assistants.<br>A facility must not use any individual working in | F948<br>F 948 | 1. No residents were adversely effected by staff #6 feeding residents without having training through a state approved feeding program. The employee was not permitted to continue feeding and will not assist with feeding residents until she receives state state approved training. | |

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| F 948 | Continued From page 47<br>the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and facility documentation review, the facility staff failed to certify an individual feeding residents participated in a state approved feeding assistant program.<br><br>The findings included:<br><br>During the initial tour of the dining room observation on the dementia care unit located on Sholom Hall a Unit Secretary was observed feeding residents on three occasions.<br><br>On 10/08/19 at approximately 12:40 PM, the Unit Secretary (Other Staff #6) was observed feeding two residents in the dining area on Sholom Hall.<br><br>On 10/09/19 at approximately 12:41 PM, the Unit Secretary (Other Staff #6) was observed feeding a resident in the dining area on Sholom Hall. Other Staff #6 was asked how long has she been assisting residents with feeding. She stated that she's been assisting residents for fours years. She voluntarily made a copy of a Certificate of Completion. The reading on the certificate stated that she had successfully completed the Assisted Oral Feedings in Adults dated August 01, 2015.<br><br>The following interviews were conducted:<br><br>On 10/10/19 at approximately 10:03 AM an interview was conducted with the Staff Development Nurse (Other Staff #5). She was asked if the above staff had completed a state | F 948 | 2. All residents requiring assistance with feeding have the potential to be affected. An observation during meal times was conducted by the unit manager and no other residents were affected. Staff #6 was relieved of her ability to assist resident with feeding.<br><br>3. Unlicensed staff that would like to feed residents will receive training through a state approved feeding program. The "Feeding Program" policy has been updated to include a State Approved training program. Staff will be inserviced by Staff Development Coordinator on the "Feeding Program" policy. Unit managers will monitor during meals weekly to ensure licensed and/or trained staff are feeding residents.<br><br>4. Unit Manager or designee will conduct weekly compliance observations and results will be reviewed during Standards of Care meeting for a minimum of 90 days. Non-compliance will be addressed through further education and/or disciplinary action as appropriate.<br><br>5. Our corrective action plan will be in place by 11/8/19. | |

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| F 948 | Continued From page 48<br>approved Feeding Assistant Program. She stated, "I Don't Know."<br><br>On 10/10/19 at approximately, 10:04 AM an interview was conducted with The Director of Human Resources (Other Staff #9). She was asked if the Feeding Assistant Program taught at the facility was state approved? She stated, "I Don't know." She was also asked if the program still exist at the facility? She stated, "No."<br><br>On 10/10/19 at approximately,10:08 AM an interview was conducted with the clinical nurse liaison, LPN #3 (Licensed Practical Nurse). She was asked if the feeding program in 2015 was a state approved program. She stated, "We haven't had a feeding program in maybe four or five years."<br><br>On 10/10/19 at approximately,10:10 AM an interview was conducted with the Unit Secretary, (Other Staff #6). She was asked to explain the training that she had received at the facility in 2015 and if any future training was received. "I received my training from a Speech Therapist." "She is no longer employed here." "I received a Certificate of Completion." "I received a few days training." "Since August 2015, I started assisting with feeding only on the Dementia Unit." She said that she is also receiving yearly training.<br><br>On 10/10/19 at approximately, 10:40 AM an interview was conducted with the Director of Nursing and the Administrator. The above concerns were discussed. No comments were voiced. They were asked for a copy of the Unit Secretary's job description and policy on feeding<br><br>On 10/10/19 at approximately, 12:21 PM a phone | F 948 | | |

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| F 948 | Continued From page 49 | F 948 | | |

interview was conducted with former Speech Therapy Director (Other Staff #8). She was asked if the feeding program at the facility was state approved. She stated, "It was not a state sponsored program" and "We did not have enough people to train so speech therapy started doing the training." Other Staff #8 stated "I was not her instructor, a former speech therapist taught her the class." She was asked if it was a state approved class. She stated "I have no idea." She was also asked if any other staff participated in the training; she stated, "I have no idea."

On 10/10/19 at approximately, 12:31 PM an interview was conducted with the Rehab. Director (Other Staff #7) concerning the above issues. She stated, "I was not here doing that time period." She was also asked if she was aware there was a Unit Secretary assisting with feeding residents on the Dementia Care unit. She stated, "No." She was then asked if the feeding assistant program still existed at the facility. She stated, "No not that I know of."

On 10/10/19 at approximately, 2:41 PM an interview was conducted with CNA (Certified Nursing Assistant) #2. She was asked how long has the unit secretary (Other Staff #6) been assisting with feeding? She stated, "I've been here at least a month, she's been helping out since." She was also asked if the above staff assisted with feeding all residents on the dementia unit. CNA #2 stated, "Whoever is available at the time."

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On 10/10/19 at approximately, 2:56 PM an interview was conducted with LPN (Licensed Practical Nurse) #5. He was asked how long has the Unit Secretary (Other Staff #6) been assisting

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| F 948 | Continued From page 50<br>with feeding the residents? He stated, "More than a year." "Staff worked in housekeeping first" "It may be longer than that." He was also asked if she feeds all residents on this unit; he stated, "We let her assist feeding with those who can't help themselves." He was then asked if they had any resident experiencing choking while being fed by the above staff member. LPN #5 stated, "I can't recall." When asked if he remembers when she received her Feeding Assistant training, he stated "I can't remember." "She does a good job with feeding and will ask questions if needed."<br><br>Unit Secretary Job Description: Greeting visitors in a positive and friendly manner, while ensuring that they sign in and out of out guest log system. Provides general office support to nursing staff and residents with a variety of clerical activities and related tasks.<br><br>Feeding Program Policy: Revision date: January 14, 2015. 1. Feeding assistants provide dining assistance only for residents with no complicated feeding problems. 2. Feeding assistants must successfully complete an approved training course taught by qualified professionals (as defined by state law) before being permitted residents.<br>3. The administrative office will maintain a record of each individual's completion of the Feeding Assistant Training Course and a record of all individuals used as feeding assistants. | F 948 | | |