STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495011	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ALEXANDRIA	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/08/19 through 10/10/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	(E 029) The statements made on this plan of correction are not and admission to and not to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. I. Corrective Action The Emergency Preparedness Plan was updated with the current facility staff contact list. II. Identification All residents in the facility have the potential to be affected by the alleged practice. III. Systematic Changes Administrator will educate all department managers on facilities Emergency Preparedness Plan/ communication plan. I.V Monitoring Administrator and or designee will complete weekly x four weeks and then monthly to assure the Emergency Preparedness Plan has the most up to date facility staff contact list. These audits will be forwarded to the Quality Assurance and Assessment Committee for review to determine if further audits or actions or needed. V. Date of Completion 11/24/19	
E 029 SS=C	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to provide evidence that the communication plan was updated. The findings include: On 10/10/19 at approximately 5:00 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence that the communication plan was updated. ASM # 1 stated, "We don't have the updated staff contact list." No further information was provided prior to exit.	E 029		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2)	E 039	(E 039)	

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

Ken Connelly, LNHA | ADMINISTRATOR | 10-25-19

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 039	Continued From page 1 (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: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (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. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (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. (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.	E 039	(E 039) The statements made on this plan of correction are not and admission to and not to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. I. Corrective Action The Administrator will schedule a full scale community base exercise and an individual base exercise followed by a table top exercise that includes a group discussion with analysis. II. Identification All residents in the facility have the potential to be affected by the alleged practice. III. Systematic Changes Administrator will educate all department managers on facilities Emergency Preparedness Plan/ communication plan. f facilities lan I.V Monitoring Administrator and or designee will audit the Emergency Preparedness Plan x four annually for completion of exercises, table top and analysis. These audits will be forwarded to the Quality Assurance and Assessment Committee for review to determine if further audits or actions or needed. V. Date of Completion 11/24/19	

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E 039	Continued From page 2 *[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: (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 of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (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. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to provide documented evidence of the annual tabletop and full-scale exercise, the facility's efforts to identify a full-scale exercise and exercise analysis, response and how the facility updated its emergency program based on the exercise analysis. The findings include: On 10/10/19 at approximately 5:00 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness	E 039		

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E 039	Continued From page 3 plan failed to evidence of documentation of the annual tabletop and full-scale exercise, the facility's efforts to identify a full-scale exercise, and exercise analysis response and how the facility updated its emergency program based on the exercise analysis. ASM # 1 stated, "We don't have the documentation." No further information was provided prior to exit.	E 039		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/08/19 through 10/10/19. Two complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 96 certified bed facility was 81 at the time of the survey. The survey sample consisted of 35 current Resident reviews and four closed record reviews.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607	F 607 The statements made on this plan of correction are not and admission to and not to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. I. Corrective Action The Administrator confirmed and reviewed the fax number for reporting to the correct state agency. II. Identification All residents in the facility have the potential to be affected by the alleged practice.	

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F 607	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement their policies for reporting an elopement to the state agency for one of 39 residents in the survey sample, Residents # 20. The facility staff failed to implement their policies to report an alleged incident of neglect to the state agency when Resident #20 eloped on 5/29/19, and was found two blocks away from the facility. The findings include: The facility policy, "Patient Protection: Abuse, Neglect, Exploitation, Mistreatment & Misappropriation Prevention" documented in part, "Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse or results in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator or the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures....Report the results of all investigation to the administrator or his or her designated representative and to other officials in accordance with State law, include to the State	F 607	III. Systematic Changes Administrator will be re- educated by the Quality Assurance Consultant to ensure all FRI's are timely to the appropriate state agency. I.V Monitoring Administrator and or designee will audit all FRIs daily x five, weekly x four and then monthly x two. These audits will be forwarded to the Quality Assurance and Assessment Committee for review to determine if further audits or actions or needed. V. Date of Completion 11/24/19	

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F 607	Continued From page 5 Survey Agency, within five (5) working days of the incident and if the alleged violation is verified appropriate corrective action must be taken." Resident #20 was admitted to the facility on 9/16/17 with a recent readmission on 7/27/19, with diagnoses that included but were not limited to: high blood pressure, diabetes, dementia and depression. The most recent MDS (minimum data set) assessment, a significant change/Medicare five day assessment, with an assessment reference date of 8/3/19, coded the resident as scoring as scoring a "14" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring extensive to limited assistance of one staff member for all of her activities of daily living. The MDS assessment, around the time of the elopement, a quarterly assessment, with an assessment reference date of 3/27/19, coded the resident as scoring a "13" on the BIMS score, indicating she was capable of making daily cognitive decisions. The resident was not coded as having any periods of inattention, disorganized thinking or altered level of consciousness. In Section G - Functional Status, the resident was coded as requiring supervision only for all of her activities of daily living, including walking and moving on and off the unit. The "Facility Reported Incident (FRI)" dated 5/29/19; documented in part, "Date of incident - 5/29/19. Incident type: Resident Elopement. Describe incident, including location and action	F 607		

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F 607	Continued From page 6 taken: See 5 day summary outcome." The "Self-Reporting Incident - FRI Day 1" dated 5/29/19, documented, "Description of Incident: Approximately 3:00 p.m., resident was brought into facility by a staff member who was leaving the facility and saw patient sitting on the side walk 2 blocks from facility. Patient stated she was she wanted to go to the bank to get money and in the process she fell on the grass. Actions Initiated: Head to toe assessment was initiated and no new abnormal skin conditions or not apparent injuries were noted --patient denied pain. Vitals done and in normal range. BIMS assessment done with a score of 15. RP (responsible party) and MD (medical doctor) notified, labs (laboratory tests) ordered to be done 5/30/19. Wander Guard placed on resident." Review of the FRI folder failed to evidence documentation that the state agency was notified of this incident. The agencies notified were APS (adult protective services), DHP (department of health professionals) and the resident's daughter. A call was placed, by this surveyor, to the state agency and it was verified that the incident had not been received by the state agency office. An interview was conducted with ASM (administrative staff member) #1, the administrator, on 10/10/19 at 10:49 a.m. When asked about the process for reporting an allegation of abuse, neglect, or an elopement to the state agency, ASM #1 stated the facility reports any allegation of abuse within two hours. The investigation is stated. If an employee is involved, they are suspended during the investigation. When asked about a resident eloping from the facility, ASM #1 stated first is to	F 607		

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F 607	Continued From page 7 get the resident back into the building. Perform a head to toe assessment. Notify the RP (responsible party) and the doctor. We still report it to the state and APS. The folder for the above incident of elopement was shown to ASM #1. ASM #1 was asked to show where the state agency was notified of the incident. ASM #1 stated he'd like to take the folder and speak with other staff members. On 10/10/19 at 11:10 a.m. ASM #2, the director of nursing, and ASM #3, the quality assurance consultant, stated, "He meant well. He thought he was sending it to your office. It was an innocent mistake." ASM #1, ASM #2, and ASM #3 were made aware of the above concern on 10/10/19 at 4:10 p.m. No further information was provided prior to exit.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609	F 609 The statements made on this plan of correction are not and admission to and not to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. I. Corrective Action An investigation was completed to ensure the safety of resident #20 which was presented to the surveyor for review along with other FRI's.	

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F 609	Continued From page 8 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to report an elopement to the State Agency for one of 39 residents in the survey sample, Resident #20. The facility staff failed to report a potential incident of neglect to the state agency when Resident #20 eloped on 5/29/19, and was found two blocks away from the facility. The findings include: Resident #20 was admitted to the facility on 9/16/17 with a recent readmission on 7/27/19, with diagnoses that included but were not limited to: high blood pressure, diabetes, dementia and depression. The most recent MDS (minimum data set) assessment, a significant change/Medicare five day assessment, with an assessment reference date of 8/3/19, coded the resident as scoring as scoring a "14" on the BIMS (brief interview for	F 609	II. Identification All residents in the facility have the potential to be affected by the alleged practice. III. Systematic Changes Administrator will be re- educated by the Quality Assurance Consultant to ensure all FRI's are timely to the appropriate state agency. I.V Monitoring Administrator and or designee will audit all FRIs daily x five, weekly x four and then monthly x two. These audits will be forwarded to the Quality Assurance and Assessment Committee for review to determine if further audits or actions or needed. V. Date of Completion 11/24/19	

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F 609	Continued From page 9	F 609		

mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring extensive to limited assistance of one staff member for all of her activities of daily living.

The MDS assessment, around the time of the elopement, a quarterly assessment, with an assessment reference date of 3/27/19, coded the resident as scoring a "13" on the BIMS score, indicating she was capable of making daily cognitive decisions. The resident was not coded as having any periods of inattention, disorganized thinking or altered level of consciousness. In Section G - Functional Status, the resident was coded as requiring supervision only for all of her activities of daily living, including walking and moving on and off the unit.

The "Facility Reported Incident (FRI)" dated 5/29/19; documented in part, "Date of incident - 5/29/19. Incident type: Resident Elopement. Describe incident, including location and action taken: See 5 day summary outcome."

The "Self-Reporting Incident - FRI Day 1" dated 5/29/19, documented, "Description of Incident: Approximately 3:)0 p.m., resident was brought into facility by a staff member who was leaving the facility and saw patient sitting on the side walk 2 blocks from facility. Patient stated she was she wanted to go to the bank to get money and in the process she fell on the grass. Actions Initiated: Head to toe assessment was initiated and no new abnormal skin conditions or not apparent injuries were noted --patient denied pain. Vitals done and in normal range. BIMS assessment done with a score of 15. RP (responsible party) and MD (medical doctor) notified, labs (laboratory tests)

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F 609	Continued From page 10 ordered to be done 5/30/19. Wander Guard placed on resident." Review of the FRI folder failed to evidence documentation that the state agency was notified of this incident. The agencies notified were APS (adult protective services), DHP (department of health professionals) and the resident's daughter. A call was placed, to the state agency and it was verified that the FRI for the incident had not been received by the state agency office. The facility policy, "Patient Protection: Abuse, Neglect, Exploitation, Mistreatment & Misappropriation Prevention" documented in part, "Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse or results in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator or the facility and to other officials(including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures....Report the results of all investigation to the administrator or his or her designated representative and to other officials in accordance with State law, include to the State Survey Agency, within five (5) working days of the incident and if the alleged violation is verified appropriate corrective action must be taken." An interview was conducted with ASM	F 609		

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F 609	Continued From page 11 (administrative staff member) #1, the administrator, on 10/10/19 at 10:49 a.m. When asked the process for reporting an allegation of abuse, neglect, or an elopement to the state agency, ASM #1 stated the facility reports any allegation of abuse within two hours. The investigation is stated. If an employee is involved, they are suspended during the investigation. When asked about elopement, ASM #1 stated first is to get the resident back into the building. Perform a head to toe assessment. Notify the RP (responsible party) and the doctor. We still report it to the state and APS. The folder for the above incident of elopement was shown to ASM #1. ASM #1 was asked to show where the state agency was notified of the incident. ASM #1 stated he'd like to take the folder and speak with other staff members. On 10/10/19 at 11:10 a.m. ASM #2, the director of nursing, and ASM #3, the quality assurance consultant, stated to the survey team, "He meant well. He thought he was sending it to your office. It was an innocent mistake." ASM #1, ASM #2, and ASM #3 were made aware of the above concern on 10/10/19 at 4:10 p.m. No further information was provided prior to exit.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record	F 641	F 641 The statements made on this plan of correction are not and admission to and not to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.	

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F 641	Continued From page 12 review, it was determined that the facility staff failed to accurately code the MDS (minimum data set) assessments for three of 39 residents in the survey sample, Residents # 81, # 35 and # 91. The findings include: 1. The facility staff failed to accurately code Resident # 81's discharge statue to community on the discharge assessment MDS (minimum data set) with an ARD (assessment reference date) of 10/04/19. Instead, the resident's discharge was coded as "Acute hospital." Resident # 81 was admitted to the facility on 08/20/19 with diagnoses that included but were not limited to low iron, high cholesterol and swallowing difficulties. Resident # 81's MDS (minimum data set), a discharge assessment with an ARD (assessment reference date) of 10/04/19, coded Resident # 81 as "03 (three) - Acute hospital" under section "A2100 Discharge Status." The facility's "Progress Notes" dated 10/04/2019 documented in part, "Discharge Planning/Discharge. Give Clarification order Salt pills 2gm [two-grams] 2tabs [two tablets] PO [by mouth] q [[every] day as supplement given by Nephrologist after follow up apt [appointment] today. RP [responsible party] made aware. Resident discharge orders given by MD [medical doctor]. Resident is going to an assisted living ...Visiting NP [nurse practitioner] aware assessment done by her no new orders given. RP was present. All personal belongings accounted for by RP. All discharge orders given to RP. All meds [medications] locked up in cart to	F 641	I. Corrective Action Resident #81 MDS was corrected immediately to reflect discharge to community. Resident #35 MDS was immediately corrected to reflect accurate date of medication administration. Resident #91 MDS was corrected immediately to reflect discharge to community II. Identification All residents in the facility have the potential to be affected by the alleged practice. III. Systematic Changes Education will be completed with MDS nurse on correct and accurate coding for discharged residents by the regional MDS coordinator. In addition, the MDS coordinator will be educated on correct and accurate reviewing of MARs and coding for medication administration. I.V Monitoring DON and/or designee will complete a random audit of discharged resident charts to ensure MDS was coded accurately weekly x four and monthly x two. In addition, random audits will be conducted weekly x four and monthly x two to ensure assessments reflect accurate and correct coding of resident medication administration. These audits will be forwarded to the Quality Assurance and Assessment Committee for review to determine if further audits or actions or needed. V. Date of Compliance 11/24/19	

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F 641	Continued From page 13 be returned to Pharmacy. All departments notified at this time. Assisted living notified about Resident condition." On 10/10/19 at 2:49 p.m., an interview was conducted with RN (registered nurse) # 3, MDS coordinator. When asked if Resident # 81's "Discharge Return Not Anticipated" MDS dated 10/04/2019 was coded correctly, RN # 3 then reviewed nurse's progress note dated 10/04/19 and the discharge MDS assessment for Resident # 81. RN # 3 stated, "It was coded in error. It should have been coded as a discharge to community." On 10/10/19 at approximately 4:10 p.m., ASM [administrative staff member] # 1, the administrator and ASM # 2, director of nursing and ASM # 3, quality assurance consultant were made aware of the findings. No further information was provided prior to exit. 2. The facility staff failed to accurately code Resident #35's MDS (minimum data set) assessments to reflect insulin injections received while in the facility. Resident #35 was admitted to the facility 05/15/2017 with a readmission on 04/14/2018 with diagnoses, that included but were not limited to diabetes mellitus (1) and hypertension (2). Resident #35's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/23/19, coded Resident #35 as scoring a 11 on the staff assessment for mental status (BIMS) of a score	F 641		

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F 641	Continued From page 14 of 0 - 15, 11- being moderately impaired for making daily decisions. Section I of the MDS documented a diagnosis of diabetes mellitus. Section N of the MDS failed to evidence documentation of Resident #35 receiving insulin (3) injections during the seven days prior to the assessment reference date of 08/23/19. The physicians order sheet dated "AUG (August) 2019" for Resident #35 documented, "Novolog Mix Flex-Pen 70/30 [mixture of rapid acting and intermediate acting insulin (4)] Units/1ML (milliliter) unit, inject 28 units subcutaneously (5) every morning for diabetes mellitus. 12/18/18." Further review of the document revealed the order "Novolog Mix Flex-Pen 70/30 Units/1ML unit, inject 12 units subcutaneously every evening for diabetes mellitus. 12/18/18," and an order documenting, "Novolin R 100Units/1ml unit [short acting insulin (6)] inject subcutaneously per sliding scale (7) before meals & at bedtime ...01/03/19." The MAR (medication administration record) dated "AUG 2019" for Resident #35 documented, "Novolog Mix Flex-Pen 70/30 Units/1ML 12/18/18, inject 28 units subcutaneously every morning for diabetes mellitus." The MAR documented the ordered insulin injections administered on the following dates and times: - "8/16/19 at 10:00 a.m., - 8/17/19 at 10:00 a.m., - 8/18/19 at 10:00 a.m., - 8/19/19 at 10:00 a.m., - 8/20/19 at 10:00 a.m., - 8/21/19 at 10:00 a.m., - 8/22/19 at 10:00 a.m., - 8/23/29 at 10:00 a.m."	F 641		

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F 641	Continued From page 15 The MAR dated "AUG 2019" for Resident #35 also documented, "Novolog Mix Flex-Pen 70/30 Units/1ML 12/18/18, inject 12 units subcutaneously every evening for diabetes mellitus." The MAR documented the insulin injections were administered as ordered on the following dates and times: - "8/16/19 at 6:00 p.m., - 8/17/19 at 6:00 p.m., - 8/18/19 at 6:00 p.m., - 8/19/19 at 6:00 p.m., - 8/20/19 at 6:00 p.m., - 8/21/19 at 6:00 p.m., - 8/22/19 at 6:00 p.m., - 8/23/29 at 6:00 p.m." The MAR dated "AUG 2019" for Resident #35 also documented, "Novolin R 100units/1ml unit Start: 01/03/19. Inject subcutaneously per sliding scale before meals & at bedtime ..." The MAR documented the insulin injections were administered on the following dates and times: - "8/16/19 at 4:30 p.m., - 8/17/19 at 7:30 a.m. and 4:30 p.m., - 8/18/19 at 7:30 a.m., 4:30 p.m. and 8:00 p.m., - 8/19/19 at 7:30 a.m., 11:30 a.m., 4:30 p.m. and 8:00 p.m., - 8/20/19 at 7:30 a.m., 4:30 p.m., and 8:00 p.m., - 8/21/19 at 11:30 a.m., 4:30 p.m. and 8:00 p.m., - 8/22/19 at 11:30 a.m., 4:30 p.m. and 8:00 p.m., - 8/23/29 at 11:30 a.m., 4:30 p.m. and 8:00 p.m." On 10/10/19 at 8:20 a.m., an interview was conducted with RN (registered nurse) #3, MDS (minimum data set) coordinator regarding the assessment process for insulin use. RN #3 stated that she utilizes RAI (Resident Assessment Instrument) manual (a guide on completing the MDS) as a reference in completing the MDS for	F 641		

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F 641	Continued From page 16 residents. RN #3 stated that she reviews the MAR's, the TAR (treatment administration record), physician orders, nurses notes and the chart to conduct her assessments. RN #3 stated that if insulin injections are received during the 7-day period before the assessment reference date they should be included on the MDS. RN #3 reviewed the medication administration record dated August 2019 and the physician's orders dated August 2019 for Resident #35 and agreed that Resident #35 did receive insulin injection during the period of August 16, 2019 through August 23, 2019. RN #3 stated that insulin should have been documented on the MDS dated 8/23/19. RN #3 reviewed section N of the MDS with the assessment reference date of August 23, 2019 for Resident #35 and agreed that it failed to document insulin injections. RN #3 stated that it must have been missed. On 10/10/19 at approximately 12:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant were made aware of the findings. No further information was provided prior to exit. Reference: 1. Diabetes mellitus is a chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. 2. Hypertension is high blood pressure. This information was obtained from the website:	F 641		

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F 641	Continued From page 17 https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 3. Insulin is a protein hormone that is synthesized in the pancreas from proinsulin and secreted by the beta cells of the islets of Langerhans, that is essential for the metabolism of carbohydrates, lipids, and proteins, that regulates blood sugar levels by facilitating the uptake of glucose into tissues, by promoting its conversion into glycogen, fatty acids, and triglycerides, and by reducing the release of glucose from the liver, and that when produced in insufficient quantities results in diabetes mellitus. This information was obtained from the website: https://www.merriam-webster.com/dictionary/insulin#medicalDictionary 4. Novolog mix flex pen 70/30- NOVOLOG MIX 70/30 is a mixture of insulin aspart protamine, an intermediate-acting human insulin analog, and insulin aspart, a rapid-acting human insulin analog, indicated to improve glycemic control in patients with diabetes mellitus. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=1861fcee-7673-4afe-a206-08fa05c0add2 5. Subcutaneous- putting a fluid into the tissue under the skin with a needle and syringe. This information was obtained from the website: https://www.diabetes.org/resources/for-students/common-terms 6. Novolin R 100- NOVOLIN R is a short-acting human insulin indicated to improve glycemic control in adults and pediatric patients with diabetes mellitus. This information was obtained	F 641		

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F 641	Continued From page 18 from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=aee7f1f3-612c-4027-8ce9-4fd1f41eed71 7. Sliding scale- a set of instructions for adjusting insulin on the basis of blood sugar test results, meals, or activity levels. This information was obtained from the website: https://www.diabetes.org/resources/for-students/common-terms 3. The facility staff failed to code Resident #91's "Discharge Status" accurately on the MDS (minimum data set) assessment, with an assessment reference date of 8/19/19. Resident #91 was admitted to the facility on 8/14/19 with diagnoses that included but were not limited to: facial injuries from a robbery attack. The most recent MDS (minimum data set) assessment, a Medicare five day assessment combined with a discharge assessment - return not anticipated, with an assessment reference date of 8/19/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating he was capable for making daily cognitive decisions. The resident was coded as being independent to requiring extensive assistance of one staff member for his activities of daily living. In Section A2100 - Discharge Status, the resident was coded as being discharged to "03" indicating he was transferred to an acute hospital. The social services note dated 8/19/19 at 1:58 p.m. documented in part, "Pt (patient) is requesting to be DC (discharged) tomorrow and he stated that he has 'stuff to do."	F 641		

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F 641	Continued From page 19 The nurse's note dated, 8/19/19 at 10:56 p.m. documented, "Patient not back from LOA (leave of absence), call placed to sister, sister stated she doesn't know where her brother is. Another number found on patient's file (number documented) called with no response." The nurse's note dated, 8/19/19 at 11:09 p.m. documented in part, "Call placed to sister again to inquire if she has anyone in mind who might have picked patient up, patient's sister informed writer that she had called two immediate family members but none of them was able to pick up her call. She went ahead to inform writer that she doesn't think her brother is coming back because he kept telling her he doesn't want to be here. In-house supervisor notified." The nurse's note dated, 8/21/19 at 11:24 a.m. documented in part, "Pt [patient] went LOA [leave of absence] on 8/19/19 in the evening shift, but never returned from LOA. Several calls placed to pt family and updated. F/U [follow up] call placed to pt daughter earlier this AM (morning) regarding pt where about and sutures that are due to be removed prior to d/c [discharge] home. Dtr [daughter] gave pt phone number to writer and said she is going to call pt to return to facility for proper d/c. Writer placed call to sister and updated her. Another f/u call placed out to pt phone, but he did not answer. Pt promptly called writer and informed writer that he is coming to facility this afternoon to get his sutures removed. Awaiting his return to facility this afternoon." The nurse's note dated, 8/23/19 at 9:46 a.m. documented, "No return from LOA f/u note. Pt never return to facility from his LOA of 8/19/19.	F 641		

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F 641	Continued From page 20 Spoke with pt on 8/21/19 and he promised to return to facility for his sutures to be removed that afternoon but never show up. Another f/u call placed to pt this AM but unable to reach. Pt is his own RP [responsible party]." An interview was conducted with RN (registered nurse) #3, the MDS coordinator; on 10/10/19 at 8:25 a.m., RN #3 was asked to review the above notes from the clinical record and the MDS assessment above. When asked if this MDS is coded correctly for the residents discharged status, RN #3 stated it was not coded correctly. When asked what reference the facility staff use to complete the MDS assessments, RN #3 stated, the RAI (resident assessment instrument) manual. The RAI manual, October 2019, documented in part, "Item Rationale o Demographic and outcome information. Steps for Assessment 1. Review the medical record including the discharge plan and discharge orders for documentation of discharge location. Coding Instructions Select the 2-digit code that corresponds to the resident's discharge status. o Code 01, community (private home/apt., board/care, assisted living, group home): if discharge location is, a private home, apartment, board and care, assisted living facility, or group home. o Code 02, another nursing home or swing bed: if discharge location is an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured,	F 641		

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F 641	Continued From page 21 disabled, or sick persons. Includes swing beds. o Code 03, acute hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 10/10/19 at 4:10 p.m. No further information was provided prior to exit.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656	F 656 The statements made on this plan of correction are not and admission to and not to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. I. Corrective Action Non pharmacological interventions were offered to resident #19 upon notification of concern. Like residents receiving PRN medications charts will be reviewed to ensure non-pharmacological interventions are attempted prior to medication plan being administered. II. Identification All residents receiving PRN pain medications have the potential to be affected by this practice. An audit of all residents receiving PRN pain medication will be completed to ensure they are offered non pharmacological intervention per the comprehensive plan of care.	

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F 656	Continued From page 22 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed implement the comprehensive care plan for the use of non-pharmacological interventions prior to the administration of a prn (as needed) pain medication [Ultracet] for one of 39 residents in the survey sample, Resident # 19. The facility staff failed to attempt non-pharmacological interventions per the comprehensive care plan prior to administering pain medication to Resident #19, on multiple dates in August and September 2019. The findings include: Resident # 19 was admitted to the facility on	F 656	III. Systematic Changes All nurses will be educated on following the comprehensive care plan with a focus on offering non pharmacological interventions prior to giving PRN pain medications by the DON/designee. I.V Monitoring The DON and Administrative Nurse team will complete a review of 5 residents MAR's weekly for 4 weeks and then monthly for 2 months of residents receiving PRN pain medication to ensure residents are offered non pharmacological intervention prior to receiving pain medication and ensuring the comprehensive plan of care is followed. Any variances to these audits will result in re- education of staff. The results of these audits will be reported to the QAPI team for review to determine further auditing needs. V. Date of Compliance 11/24/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495011	A. BUILDING _____ B. WING _____	C 10/10/2019

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F 656	Continued From page 23 10/20/2018 with diagnoses that included but were not limited to: osteoarthritis [2], left shoulder pain and muscle weakness. Resident # 19's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/30/19, coded Resident # 19 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 - being moderately impaired of cognition for making daily decisions. Section "J0400 Pain Frequency" coded Resident # 19 as experiencing pain "Frequently" and section "J0600 Pain Intensity as "5 [five]" on a pain scale of zero to ten, with ten being the worse pain. The comprehensive care plan for Resident # 19 with a revision date of "04/30/2019" documented, "Focus. Pain to feet, knees and chest as evidenced by c/o [complaint of] discomfort related to arthritis, neuropathy, left shoulder deformity, chest pain, right medial heel, abdominal pain." Under "Interventions" it documented, "Implement non-drug therapies such as reading, music, puzzles or other activities of choice to assist with pain and monitor for effectiveness. Revision on 08/21/2019." The MAR [medication administration record] for Resident # 19 dated "SEPT [September] 2019" documented, "Tramadol HCL [hydrochloride] - Acetaminophen F/C [film coated]. 37.5-325MG [milligram] TABLET. ULTRACET. 1 [one] TAB [tablet] EVERY 6 [six] HOURS AS NEEDED FOR LEG PAIN. Start 08/15/19." Review of the MAR revealed on 09/02/19 at 6:00 a.m. and on 09/08/19 at 5:25 a.m., Ultracet was administered to Resident # 19. Further review of the MAR failed to evidence documentation of	F 656		

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F 656	Continued From page 24 non-pharmacological interventions prior to the administration of Ultracet on the above dates. The MAR [medication administration record] for Resident # 19 dated "AUG [August] 2019" documented, "Tramadol HCL [hydrochloride] - Acetaminophen F/C [film coated]. 37.5-325MG [milligram] TABLET. ULTRACET. 1 [one] TAB [tablet] EVERY 6 [six] HOURS AS NEEDED FOR LEG PAIN." Review of the MAR revealed on 08/18/19 at 6:00 p.m., 08/18/19 at 1:00 a.m. and on 08/28/19 at 2:00 a.m., Ultracet was administered to Resident # 19. Further review of the MAR failed to evidence documentation of non-pharmacological interventions prior to the administration of Ultracet on the above dates. Review of the facility's "Nursing Progress Notes" dated 09/02/19, 09/08/19 08/18/19, 08/18/19 and on 08/28/19 failed to evidence documentation of non-pharmacological interventions attempted prior to the administration of Ultracet on the above dates. On 10/10/19 at 10:40 a.m., an interview was conducted with LPN [licensed practical nurse] # 3. When asked to describe the purpose of the care plan LPN # 3 stated, "For the resident's well-being and it tells us how to take care of the patient." After reviewing the pain comprehensive care plan for Resident # 19, LPN # 3 was asked if the care plan was being implemented for the use of non-pharmacological interventions. LPN # 3 stated, "It wasn't being followed." The facility's policy "Interdisciplinary Care Planning" documented in part, "Implementation. Once the care plan is developed, the staff must implement the interventions identified in the care	F 656		

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F 656	Continued From page 25 plan. These may include, but not limited to: administering treatments and medications, performing therapies, and participating in activities with the patient." On 10/10/19 at approximately 4:10 p.m., ASM [administrative staff member] # 1, the administrator and ASM # 2, director of nursing and ASM # 3, quality assurance consultant were made aware of the findings. No further information was provided prior to exit. References: [1] Ultracet contains a combination of tramadol and acetaminophen. Tramadol is an pain medicine similar to an opioid (sometimes called, a narcotic). Acetaminophen is a less potent pain reliever that increases the effects of tramadol. Ultracet is used to treat moderate to severe pain. This information was obtained from the website: https://www.drugs.com/ultracet.html. [2] The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website: https://medlineplus.gov/osteoarthritis.html.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684	F 684 The statements made on this plan of correction are not and admission to and not to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.	

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F 684	Continued From page 26 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide treatment and care in accordance with professional standards of practice, and the comprehensive care plan, for one of 39 residents in the survey sample, Resident # 19. The facility staff failed to follow physician's orders to obtain vital signs for seven days. The staff only obtained Resident #19's vital signs for 6 days. The findings include: Resident # 19 was admitted to the facility on 10/20/2018 with diagnoses that included but were not limited to: left shoulder pain and muscle weakness. Resident # 19's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/30/19, coded Resident # 19 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 - being moderately impaired of cognition for making daily decisions. The "Physician's Interim/Telephone Orders" for Resident # 19 dated 06/24/19 documented in part, "3. BP [blood pressure] and Heart rate check daily x [times] 7d [seven days]." The MAR [medication administrative record] dated "June 2019" documented the "Physician's Interim/Telephone Orders" as documented above.	F 684	I. Corrective Action Resident #19's vital signs were taken upon notification of concern and the physician was notified. II. Identification All residents receiving physician orders for vital signs have the potential to be affected by this practice. A review of all residents that have physician orders for vital signs was completed to ensure physician orders are followed. III. Systematic Changes All licensed nurses will be educated on following physician orders. I.V Monitoring The DON and Administrative nurses will review all new orders daily for 4 weeks to include admission orders and then monthly for 2 months to ensure physician orders are followed. Any variances will be corrected, the physician will be notified and reeducation provided. The results of these audits will be reported to the QAPI team for review to determine further auditing. V. Date of Completion 11/24/19	

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F 684	Continued From page 27 The MAR documented Resident # 19's blood pressure and heart rate on 06/25/19 through 06/30/19 for six days. Further review of the MAR failed to evidence Resident # 19's blood pressure and heart rate was obtained on a seventh day. The MAR [medication administrative record] dated "July 2019" failed to evidence Resident # 19's blood pressure and heart rate was obtained to meet the physician's order for seven days. Review of the facility's nursing progress notes dated 06/24/19 through 07/01/19 failed to evidence Resident # 19's blood pressure and heart rate was obtained to meet the physician's order for seven days. On 10/10/19 at 10:40 a.m., an interview was conducted with LPN [licensed practical nurse] # 3. After reviewing the Physician's Interim/Telephone Orders" for Resident # 19 dated 06/24/19, the June and July MARs dated 2019 and the nursing progress notes dated 06/24/19 through 07/10/19, LPN # 3 was asked about the number of days Resident # 19's blood pressure and heart rate was obtained. LPN # 3 stated, "It was only obtained for six days, there's one day missing." When asked why it was important to follow the physician's orders LPN # 3 stated, "So the patient can get well." On 10/10/19 at approximately 4:10 p.m., ASM [administrative staff member] # 1, the administrator and ASM # 2, director of nursing and ASM # 3, quality assurance consultant were made aware of the findings. No further information was provided prior to exit.	F 684		

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F 689	Continued From page 28	F 689		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and facility document review it was determined that facility staff failed to ensure hazardous chemicals were stored in a safe manner for one of 39 residents in the survey sample. Two cans of pesticides were stored on the floor in front of the wardrobe in Resident #35's room. The findings include: Resident #35 was admitted to the facility 05/15/2017 with a readmission on 04/14/2018 with diagnoses, that included but were not limited to diabetes mellitus (1) and hypertension (2). Resident #35's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/23/19, coded Resident #35 as scoring a 11 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 11- being moderately impaired for making daily decisions. On 10/8/19 at 4:57 p.m., an observation of	F 689	F 689 The statements made on this plan of correction are not and admission to and not to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. I. Corrective Action Resident #35 Insecticides were removed immediately. Family was educated regarding facilities policy on chemical use and storage. II. Identification All residents in the facility have the potential to be affected by the alleged practice. III. Systematic Changes Staff will be educated and re-educated on facility policy on chemical use and storage.	

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F 689	Continued From page 29 Resident #35's room revealed a 17.5 ounce can of [Brand Name] ant killer and an 18 ounce can of [Brand Name] flying insect killer on the floor to the left side of the resident's bed in front of the wardrobe. The resident was not present in the room. On 10/9/19 at 9:15 a.m., an additional observation of Resident #35's room revealed the findings above. Resident #35 was not present in the room. On 10/9/19 at 3:30 p.m., an additional observation of Resident #35's room revealed the findings above. Resident #35 was present in the room in a wheelchair at the left side of the bed. On 10/9/19 at 3:30 p.m., an interview was conducted with Resident #35. Resident #35 was asked about the 17.5-ounce can of Raid ant killer and the 18 ounce can of Raid flying insect killer located on the floor in front of the wardrobe to the left of the bed in the residents room. Resident #35 stated that her aide who comes in to care for her brought them to her in the summer to help with the mosquitos. When asked if she uses the bug spray Resident #35 stated that she does when there are mosquitos. On 10/9/19 at 4:30 p.m., an interview was conducted with RN (registered nurse) #1, nurse supervisor. When asked how chemicals are stored, RN #1 stated that they are locked. When asked if chemicals are stored in residents rooms, RN #1 stated, "There are no chemicals in resident rooms." When asked why, RN #1 stated that there is a swallowing hazard and possibly an inhalation hazard if they are in the rooms. RN #1 stated confused residents could wander in the	F 689	I.V Monitoring **Maintenance Director and/or designee will round on resident's rooms to ensure residents are free of hazardous chemicals and chemicals are stored in a safe manner 5 rooms daily x 5, weekly x 4 and then monthly x 2.** These audits will be sent to the Quality Assurance Assessment committee to determine if further audits or actions or needed. V. Date of Completion 11/24/19	

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F 689	Continued From page 30 room and access the chemicals. When asked what staff do if chemicals are found in a resident room, RN #1 stated that they are removed and whoever is responsible for them is called to get rid of them or keep them in a specific area. When asked if rounds are conducted of resident rooms, RN #1 stated that nursing rounds are completed every shift inspecting the resident rooms. RN #1 stated that housekeeping and maintenance also round in resident rooms at least daily. When asked if nursing rounds included checking the environment for hazards such as chemicals, RN #1 stated, "Yes." On 10/9/19 at 4:40 p.m., an interview was conducted with OSM (other staff member) #3, the maintenance director. When asked how chemicals are stored, OSM #3 stated that they are locked on carts and in storage. When asked if chemicals are stored in resident's rooms, OSM #3 stated, "Residents cannot have them in the rooms." When asked why, OSM #3 stated, "For safety purposes, the resident could ingest them or could spray them in their face." When asked if rounds are conducted of resident rooms, OSM #3 stated that nursing rounds and housekeeping rounds are completed every shift and maintenance inspects rooms every day. When asked when Resident #35's room was last inspected by maintenance, OSM #3 stated on 10/8/19. An observation was conducted with OSM #3 of Resident #35's room, which revealed the 17.5 ounce can of [Brand Name] ant killer and an 18 ounce can of flying insect killer located on the floor to left side of the resident's bed in front of the wardrobe. OSM #3 stated that the cans were not chemicals used by the facility and that a family member or visitor to Resident #35 had probably brought them in. OSM #3 stated that	F 689		

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F 689	Continued From page 31 these should have been seen on room rounds and removed. OSM #3 stated that all residents and families are informed on admission of the fact that they cannot bring chemicals to store in the resident's rooms and that reeducation would be completed. OSM #3 removed the two cans of Raid from the resident's room. The facility policy "Chemical Use and Storage, September, 2014" documented in part, "Chemicals are used for a variety of cleaning and sanitizing functions. Consideration is given to their proper use and storage to minimize the risk of food contamination and injury to employees and patients ... Aerosols are stored in a flameproof cabinet." The facility policy "Rounds, Date: 08/11/06, Revised: 11/2013" documented in part, "Purpose: To provide a method that assists the user to monitor and observe systems or processes related to clinical, administrative or environmental areas ...environmental: safety, housekeeping/environmental services ..." The document provided by the facility "Safety Data Sheet, [brand Name] Max Ant & Roach, Print date 09/07/2016, Revision Date 05/27/2015" documented in part, "Hazard statements, Flammable aerosol. Contains gas under pressure; may explode if heated." Further review of the document revealed, "Avoid contact with skin, eyes and clothing. Do not enter places where used or stored until adequately ventilated ...Do not spray in enclosed areas ...Keep away from food, drink ...Causes moderate eye irritation ..." The documented provided by the facility "Material	F 689		

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F 689	Continued From page 32 Safety Data Sheet, [Brand Name] of Commercial Flying Insect Killer, Preparation date: 2009-06-22 (6/22/09)" documented in part, "May be mildly irritating to eyes, Prolonged or repeated contact may dry skin and cause irritation. Harmful if absorbed through skin. May be irritating to nose, throat, and respiratory tract." On 10/9/19 at approximately 5:20 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the quality assurance consultant were made aware of the findings. On 10/10/19 at approximately 10:00 a.m., ASM #1, the administrator stated that the aide who works for Resident #35 had brought in the two cans of insect spray and that reeducation had been conducted with Resident #35 and Resident #35's family. No further information was provided prior to exit. Reference: 1. Diabetes mellitus A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. 2. Hypertension High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 689		
F 730	Nurse Aide Peform Review-12 hr/yr In-Service	F 730	F 730 The statements made on this plan of correction are not and admission to and not to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.	

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F 730 SS=D	Continued From page 33 CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and employee record review it was determined that the facility staff failed to ensure that two of ten CNA (certified nursing assistant) records reviewed received the required 12 hours of annual training, (CNA (certified nursing assistant) #9 and #10). Review of CNA #9 and #10's training transcripts revealed the required 12-hours of annual training was not completed. The findings include: On 10/03/19 at 8:15 a.m., a review of the facility's CNA [certified nursing assistant], annual training was conducted. Review of ten CNA training transcripts revealed two of ten CNAs selected for review did not meet the required 12-hours of annual training. Review of CNA # 9's training transcript documented a hire date of 02/15/2016. Further review of the training transcript dated 12/15/17 through 12/15/18 documented, "Total Hours: 8.74." Review of CNA # 10's training transcript documented a hire date of 02/20/2015. Further review of the training transcript dated 02/20/18	F 730	I. Corrective Action **CNA #9 completed in-services per policy** **CNA #10 completed in-services per policy** II. Identification All residents in the facility have the potential to be affected by the alleged practice. III. Systematic Changes Human Resources Director will be educated to follow up and ensure required CNA training is completed per state regulation CNAs will be re-educated on ensuring required in-services are done per policy/ state requirements I.V Monitoring Human Resources Director and/ or designee will review CNAs records to ensure required 12 hours / year are completed 5 random records daily x five, weekly x four and then monthly x two. These audits will be sent to the Quality Assurance Assessment Committe to determine if further audits or actions or needed. V. Date of Completion 11/24/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495011	A. BUILDING _____ B. WING _____	C 10/10/2019

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F 730	Continued From page 34 through 02/20/19 documented, "Total Hours: 6.75." On 10/10/19 at 2:10 p.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing regarding the CNA's annual training. ASM # 2 stated, "The training was assigned but it was not completed. Human resources reviews the training quarterly and brings it up in the morning meeting and lets the department heads know who needs to complete the training. The department heads let their staff know who needs to complete training." On 10/10/19 at 4:30 p.m., an interview was conducted with OSM [other staff member] # 8, director of human resources. OSM # 8 stated that she has only been at the facility for two months. When asked about monitoring CNA's annual training, OSM #8 stated, that she "would be doing monthly tracking and that the corporate office would also be tracking and sending monthly emails of staff who need to complete training." On 10/10/19 at approximately 4:10 p.m., ASM [administrative staff member] # 1, the administrator and ASM # 2, director of nursing and ASM # 3, quality assurance consultant were made aware of the findings. No further information was provided prior to exit.	F 730		
			F 757	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757	**The statements made on this plan of correction are not and admission to and not to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.**	

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F 757	Continued From page 35 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure the drug regimen must be free from unnecessary drugs for one of 39 residents in the survey sample, Resident # 19. The facility staff failed to attempt non-pharmacological interventions prior to the administration of a prn (as needed) pain medication [Ultracet] on multiple dates in August and September 2019. The findings include: Resident # 19 was admitted to the facility on 10/20/2018 with diagnoses that included but were not limited to: osteoarthritis [2], left shoulder pain and muscle weakness. Resident # 19's most recent MDS (minimum data	F 757	I. Corrective Action Non pharmacological interventions were offered to resident #19 upon notification of concern. Like residents receiving PRN medications charts will be reviewed to ensure non-pharmacological interventions are attempted prior to medication plan being administered. II. Identification All residents receiving PRN pain medications have the potential to be affected by this practice. An audit of all residents receiving PRN pain medication will be completed to ensure they are offered non pharmacological intervention per the comprehensive plan of care. III. Systematic Changes All nurses will be educated on following the comprehensive care plan with a focus on offering non pharmacological interventions prior to giving PRN pain medications by the DON/designee. I.V Monitoring The DON and Administrative Nurse team will complete a review of 5 residents MAR's weekly for 4 weeks and then monthly for 2 months of residents receiving PRN pain medication to ensure residents are offered non pharmacological intervention prior to receiving pain medication and ensuring the comprehensive plan of care is followed. Any variances to these audits will result in re- education of staff. The results of these audits will be reported to the QAPI team for review to determine further auditing needs. V. Date of Compliance 11/24/19	

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F 757	Continued From page 36 set), a quarterly assessment with an ARD (assessment reference date) of 07/30/19, coded Resident # 19 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 - being moderately impaired of cognition for making daily decisions. Section "J0400 Pain Frequency" coded Resident # 19 as "Frequently" and section "J0600 Pain Intensity as "5 [five]" on a pain scale of zero to ten, with ten being the worse pain. The MAR [medication administration record] for Resident # 19 dated "SEPT [September] 2019" documented, "Tramadol HCL [hydrochloride] - Acetaminophen F/C [film coated]. 37.5-325MG [milligram] TABLET. ULTRACET. 1 [one] TAB [tablet] EVERY 6 [six] HOURS AS NEEDED FOR LEG PAIN. Start 08/15/19." Review of the MAR revealed on 09/02/19 at 6:00 a.m. and on 09/08/19 at 5:25 a.m., Ultracet was administered to resident # 19. Further review of the MAR failed to evidence documentation of non-pharmacological interventions prior to the administration of Ultracet on the above dates. The MAR [medication administration record] for Resident # 19 dated "AUG [August] 2019" documented, "Tramadol HCL [hydrochloride] - Acetaminophen F/C [film coated]. 37.5-325MG [milligram] TABLET. ULTRACET. 1 [one] TAB [tablet] EVERY 6 [six] HOURS AS NEEDED FOR LEG PAIN." Review of the MAR revealed on 08/18/19 at 6:00 p.m., 08/18/19 at 1:00 a.m. and on 08/28/19 at 2:00 a.m., Ultracet was administered to resident # 19. Further review of the MAR failed to evidence documentation of non-pharmacological interventions prior to the administration of Ultracet on the above dates.	F 757		

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F 757	Continued From page 37 Review of the facility's "Nursing Progress Notes" dated 09/02/19, 09/08/19 08/18/19, 08/18/19 and on 08/28/19 failed to evidence documentation on non-pharmacological interventions prior to the administration of Ultracet on the above dates. The comprehensive care plan for Resident # 19 with a revision date of "04/30/2019" documented, "Focus. Pain to feet, knees and chest as evidenced by c/o [complaint of] discomfort related to arthritis, neuropathy, left shoulder deformity, chest pain, right medial heel, abdominal pain." Under "Interventions" it documented, "Implement non-drug therapies such as reading, music, puzzles or other activities of choice to assist with pain and monitor for effectiveness. Revision on 08/21/2019." On 10/10/19 at 10:40 a.m., an interview was conducted with LPN [licensed practical nurse] # 3. Regarding the procedure staff follows for administering an as needed pain medication. LPN # 3 stated, "Ask the resident what the pain is one to ten, ten being worse, check the MAR [medication administration record] for what medication they get according to their level of pain, mild, moderate, severe, then document the date, hour, nurse's initials, type of medication, and reason for the medication. Then in 30 to 45 minutes you go back and see if it was effective and then write it under results on the back of the MAR, then you document it in the nurse's notes on the computer [in the electronic health record]." When asked if she provides non-pharmacological intervention before giving the medication, LPN # 3 stated, "Yes." When asked where non-pharmacological interventions are documented, LPN # 3 stated, "On the computer in the nurse's notes."	F 757		

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F 757	Continued From page 38 Review of the nurse's notes 3 dated 09/02/19, 09/08/19 08/18/19, 08/18/19 and 08/28/19 was conducted with LPN # 3. When asked to provide documentation of the non-pharmacological interventions for the above dates, LPN # 3 stated, "It wasn't done." When asked why it was important to attempt non-pharmacological approaches before administering a prn pain medication, LPN # 3 stated, "Maybe you can alleviate the pain without medication." The facility's policy "Pain Practice Guide" documented in part:, "Ongoing Management Strategies: On the basis of information obtained and analysis performed in the assessment and planning phase, the next step is to implement and organized approach for the management of the patient's pain. Patients with pain are cared for in an environment that is comfortable and supportive as possible. Non-pharmacological interventions and medications are approaches used to prevent and reduce pain. The approaches are individualized to meet the patient's needs." Under "NON-PHARMACOLOGICAL INTERVENTIONS" it documented, "Interventions include non-pharmacological as well as pharmacologic. Non-pharmacologic approaches used as initial interventions can minimize the need for medications, permit use of the lowest dose or result in discontinuation of medication." On 10/10/19 at approximately 4:10 p.m., ASM [administrative staff member] # 1, the administrator and ASM # 2, director of nursing and ASM # 3, quality assurance consultant were made aware of the findings.	F 757		

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F 757	Continued From page 39 No further information was provided prior to exit. References: [1] Ultracet contains a combination of tramadol and acetaminophen. Tramadol is an pain medicine similar to an opioid (sometimes called, a narcotic). Acetaminophen is a less potent pain reliever that increases the effects of tramadol. Ultracet is used to treat moderate to severe pain. This information was obtained from the website: https://www.drugs.com/ultracet.html. [2] The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website: https://medlineplus.gov/osteoarthritis.html.	F 757		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812	F 812 The statements made on this plan of correction are not and admission to and not to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. I. Corrective Action Items not dates were discarded immediately. OSM# 2 immediately re-educated dietary staff on preparing, storing and serving food in a sanitary manner OSM's were re-educated II. Identification All residents in the facility have the potential to be affected by the alleged practice.	

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F 812	Continued From page 40 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined facility staff failed to serve and store food in a sanitary manner. The Facility staff failed to document an opened date on dry goods in the kitchen, failed to store thickening agents covered when not in use, failed to store staff food separately from resident food in the stand-up refrigerator and failed to discard food past its use by date in the walk in refrigerator. The findings include: On 10/8/19 at approximately 11:25 a.m., an observation of the facility's kitchen was conducted with OSM (other staff member) #2, the dietary manager. Observation of the kitchen area revealed a silver food preparation table containing four opened bags of pasta. Further observation of the bags revealed one ten pound bag of macaroni noodles approximately one-half full, a one pound bag of gluten free penne pasta approximately one-fourth full, a ten pound package of fettucine approximately three-quarter full, and a ten pound bag of vegetable bow tie pasta approximately one-third full. Observation of the packages failed to evidence an opened or use by date. OSM #2 stated that the four pasta packages should have an opened and use by date on them. Further observation of the kitchen area revealed a 25-pound box containing a clear plastic bag with a white powdered substance inside located	F 812	**VI. Monitoring** The dietary manager will complete inspection of all opened food items checking for open dates present, storage of thickened agents ensuring covered when in use, the stand- up refrigerator for staff food not being stored with resident's food as well as discarding food past it's discard date daily for 4 weeks, 2x/week for 4 weeks and then 2x/ month for 2 months. Any variances will be corrected, and education provided. The results of these audits will be reported to the QAPI team for review to determine further auditing. V. Date of compliance. 11/24/19	

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F 812	Continued From page 41 underneath a food prep table. OSM #2 stated that the box contained thickener. The box was observed open on the top with the plastic bag surrounding the edges of the box leaving the thickener exposed to air. OSM #2 stated that the thickener should be closed, dated and not open to air. Observation of the stand-up refrigerator in the kitchen revealed a blue plastic bag labeled and dated in marker "10/8/19 [First name]" located behind supplement shakes and milk cartons. When asked what was in the bag, OSM #2 stated that she was not sure but the bag contained the name of one of the cooks. Observation of the contents of the bag revealed a blue topped plastic storage container with food inside. When asked if the food was for residents use, OSM #2 stated that it was not for residents and should not be kept in the refrigerator. OSM #2 stated that it appeared to be a staff member's food and should be in the employee break room not in the kitchen. Observation of the walk in refrigerator in the kitchen revealed a silver baking pan containing baked muffins covered in foil. The label on the muffins was observed to have a use by date of 9/30/19. When asked about the muffins, OSM #2 stated that there were approximately 30 muffins in the pan and that they were past their use by date and they should have been discarded. OSM #2 stated that the contents of the refrigerator are checked each day for expired items and these should have been thrown away. Further observation of the refrigerator revealed a five-pound container of sour cream with approximately two-thirds of the contents inside. The sour cream failed to evidence an opened date or use by date. A one-pound container of	F 812		

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F 812	Continued From page 42 chicken base that was three quarters full was observed beside the sour cream container on the second shelf of the walk in refrigerator. The chicken base failed to evidence an opened date or use by date. On 10/8/19 at 5:25 p.m., an interview was conducted with OSM #2. When asked about the process for checking for food products past their use by date in the walk in refrigerator, OSM #2 stated that items are checked daily. OSM #2 stated staff overlooked the muffins and should have discarded them. When asked about the process followed by staff for opening products, OSM #2 stated that items should be dated with an opened date and a use by date. When asked why staff follow this process, OSM #2 stated so that everyone knows when things were opened and how long it is to be kept. OSM #2 stated that all items observed without an opened date were discarded because they did not know when they had been opened and they could not say when the use by date was. When asked the process for storage of employee food OSM #2 stated that employees are to store their personal foods in the break room refrigerator that is not located in the kitchen with food for residents. When asked the process for storage of thickener OSM #2 stated that it should be closed and not left open to air. The facility policy "Introduction to safe food handing, Date: September, 2014" documented in part, "Maintaining food safety is dependent upon staff's understanding and implementation of safe food handling practices. There are many steps in food production and service that affect food safety, from purchasing and receiving, to storing, preparing, cooking, holding, cooling, reheating and serving food ...For additional information,	F 812		

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F 812	Continued From page 43 refer to ServSafe Manager, 6th edition (1), or the 2013 Food Code (2)." The facility policy "Refrigerated Foods- Shelf Life after coded date" documented in part, "Product, Sour Cream, Refrigerated-7-14 days." The facility policy "Storage of Food, Date: September, 2014" documented in part, "There are many food safety aspects to consider regarding food storage. What is done with foods once deliveries are received, how they are labeled, how long they are stored, where they are stored and the temperature at which they are stored are just a few of the considerations ... 6. Store food stock and products in National Sanitation Foundation approved sanitary storage containers with lids, or in food quality plastic bags, and label as to contents and date where appropriate. Store flour, sugar and similar foods in air tight containers with the handle of the scoops out of the food product ... Label opened foods following date marking guidelines ... Discard food that has exceeded the expiration date or when use-by date is unclear." On 10/9/19 at approximately 5:20 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the quality assurance consultant were made aware of the findings. No further information was provided prior to exit. References: 1. ServSafe Manager, 6th edition The ServSafe® program is developed by the National Restaurant Association with the help of	F 812		

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F 812	Continued From page 44 foodservice industry experts who face the same risks you do every day. Your concerns are our concerns. Our years of experience and inside knowledge of the foodservice industry are at the core of our courses, exams and materials. We can prepare you to handle food sanitation risks because we have direct experience with it. We also have reliable materials, flexible options, and expert food safety educators. This information was obtained from the website: https://www.servsafe.com/ServSafe-Manager/The-ServSafe®-Food-Safety-Advantage 2. 2017 Food Code The Food Code is a model for safeguarding public health and ensuring food is unadulterated and honestly presented when offered to the consumer. It represents FDA's best advice for a uniform system of provisions that address the safety and protection of food offered at retail and in food service. This information was obtained from the website: https://www.fda.gov/food/fda-food-code/food-code-2017	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880	F 880 The statements made on this plan of correction are not and admission to and not to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495011	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ALEXANDRIA	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 45 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880	I. Corrective Action CNA #2 in-serviced immediately on policy II. Identification All residents in the facility have the potential to be affected by the alleged practice. III. Systematic Changes **Staff will be re-educated on following infection control practices/ protocol to ensure food are served in a sanitary manner per policy** IV. Monitoring **Food Services Director and/or designee will do dinning observation on all three meals to ensure food are served in a sanitary manner daily x five, weekly x four and then monthly x 2.** These audits will be forwarded to the Quality Assurance and Assessment Committee for review to determine if further audits or actions or needed. V. Date of Compliance 11/24/19 RECEIVED NOV 07 2019 VDH/OLC	

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F 880	Continued From page 46 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to serve food in a sanitary manner in the main dining room during the lunch meal on 10/8/19. When removing the plates from the tray, CNA (certified nursing assistant) #2, was observed with his thumb on the food, contact surface area of the residents' plates for the resident he served. The findings include: On 10/8/19 at 12:45 p.m. an observation of the dining service was conducted in the main dining room of the facility. Ten residents were observed seated at tables consisting of two to four table settings in the dining room. CNA (certified nursing assistant) #2 was observed serving residents drinks table to table. At 12:55 p.m., after serving all residents drinks, CNA #2 was observed obtaining a large carrying tray containing two lunch plates from the dining service line located in the dining room. CNA #2	F 880		

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F 880	Continued From page 47 served two residents seated at a table together from the large tray. CNA #2 was observed picking the plate up with his right hand while holding the large tray in his left hand. The thumb of his right hand was observed touching the rim of the plate when serving the plate to the resident. CNA #2 proceeded to serve the second plate to the other resident at the table. The thumb of his right hand was touching the rim of the plate. CNA #2 then proceeded to carry the large carrying tray back to the service line to get plates of food for the other 10 residents and serve them table by table. CNA #2 was observed touching the rim of each plate with his thumb when serving the plates of food to the residents in the dining room. The last resident was served at 1:10 pm. On 10/8/19 at 3:05 p.m., an interview was conducted with CNA #2 regarding the lunch observation in the dining room. When asked how plates are handled when serving the food in the dining room, CNA #2 stated that the plates are served at the same time for residents at the same table by placing them on the large tray. When asked how the plate should be handled, CNA #2 stated that it is handled from the bottom of the plate. When asked why, CNA #2 stated to keep it clean and not contaminate the food. When asked if he normally holds the large tray in one hand and serves the plates with the other hand, CNA #2 stated, "Yes". When asked about the observation of handling of the plates with the thumb touching the rim of the plates, CNA #2 stated that he did not realize that he was touching the plate. CNA #2 stated he normally handles them from the bottom and tries to not touch them on rim. ServSafe Manager (3) documents in section 7.7,	F 880		

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F 880	Continued From page 48 "Service staff must be as careful as kitchen staff. They can contaminate food simply by handling the food-contact areas of glasses, dishes, and utensils ...Hold dishes by the bottom or edge; Do not touch the food-contact areas of dishes or glassware." On 10/9/19 at approximately 5:20 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the quality assurance consultant were made aware of the findings. No further information was provided prior to exit. References: 1. Servsafe manager. (2017) (7th ed.). The flow of Food: Service. Section 7.7.	F 880		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a functioning to call light system for three of 39 residents in the survey, Resident #54, Resident #66 and Resident #290.	F 919	F 919 The statements made on this plan of correction are not and admission to and not to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. I. Corrective Action Residents #54, #66 & #290 Call light systems immediately fixed by maintenance director. Call light vendor notified immediately to assess system.	

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F 919	Continued From page 49 The findings include: Resident #54 was admitted to the facility on 9/3/19 with diagnoses that include but are not limited to: cerebrovascular accident [hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack resulting in loss of ability to move body part or speak. (1)], atrial fibrillation [rapid and random contraction of the atria of the heart causing irregular heartbeat. (2)] and major depressive disorder (dejected state of mind with feelings of sadness, discouragement and hopelessness often accompanied by reduced activity (3)]. The MDS (minimum data set) assessment, a 14 day Medicare assessment, with an ARD (assessment reference date) of 9/10/19, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating he is cognitively intact. Resident #66 was admitted to the facility on 9/3/19 with diagnoses that include but are not limited to: cerebrovascular accident [hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack resulting in loss of ability to move body part or speak. (4)], dysphagia [impairment in the ability to swallow. (5)] and high blood pressure. The MDS (minimum data set) assessment, a 14 day Medicare assessment, with an ARD (assessment reference date) of 9/17/19, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating she is cognitively intact. On 10/8/19 at 3:03 PM, an interview was conducted with Resident #54. When asked if his call light was functioning, Resident #54 stated, "I	F 919	II. Identification All residents in the facility have the potential to be affected by the alleged practice. III. Systematic Changes Staff will be re-educated to do rounds per policy ensuring residents call light systems are functioning. IV. Monitoring **Maintenance Director and/or designee will round on all resident's rooms to ensure residents call light systems are functioning five rooms daily x five, weekly x four and then monthly x two** utilizing room rounding tool for documentation. These audits will be forwarded to the Quality Assurance and Assessment Committee for review to determine if further audits or actions or needed. V. Date of Compliance 11/24/19	

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F 919	Continued From page 50	F 919		

don't think it works." When Resident #54 pushed the call light, no light (in room or outside door) or sound was noted. Resident #54 was asked to push call light a second time no light (in room or outside door) or sound was noted.

On 10/8/19 at 3:13 PM, an interview was conducted with Resident #66 [Resident #54's roommate]. When asked if her call light was functioning, Resident #66 stated, "I haven't used it much. I don't know." When Resident #66 pushed her call light, no light (in room or outside door) or sound was noted. At this time, LPN (licensed practical nurse) #1 was asked to come to Resident #54's and #66's room to check the call lights. When LPN #1 pushed the call lights for Resident #54 and #66, no lights (in room or outside door) or sounds were produced. LPN #1 then left the room and immediately returned with metal hand bells, which she provided to Resident #54 and #66. LPN #1 stated she was calling maintenance department.

On 10/8/19, at approximately 3:16 p.m., OSM (other staff member) #3, the maintenance director, was observed arriving on floor where Resident #54 and #66 reside. OSM #3 was observed checking the call lights for Resident #54 and #66. After testing the residents call lights, which were observed without light or sound when pushed, OSM #3 was observed replacing the call light cord for both call lights. The call lights were then tested and observed to be functional.

The above observations regarding the call lights for Resident #54 and #66 were shared with the survey team on 10/8/19 at 4:10 PM. On 10/8/19 at 4:30 PM, an audit of all call bells was conducted. Two additional non-functioning call

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F 919	Continued From page 51 lights were identified. Resident #290's call bell and the unoccupied B bed in Resident 290's room. Resident #290 was admitted to the facility on 10/1/19 with diagnoses that include but are not limited to: cerebrovascular accident [hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack resulting in loss of ability to move body part or speak. (6)], dysphagia [impairment in the ability to swallow. (7)] and heart failure [inability of the heart to pump enough blood to maintain normal body requirements (8)]. The MDS (minimum data set) assessment, a 5 day Medicare assessment, with an ARD (assessment reference date) of 10/7/19, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating she is cognitively intact. On 10/8/19 at 4:43 PM, an interview was conducted with Resident #290. When asked if her call light was functioning, Resident #290 stated, "It hasn't been working. It's been a few days." When Resident #290's call light was pushed, no light (in room or outside door) or sound was noted. At this time, LPN (licensed practical nurse) #1 was asked to come to Resident #290's room to check the residents call light. When LPN #1 pushed Resident #290's call light, no light (in room or outside door) or sound was produced. LPN #1 then left the room and immediately returned with a metal hand bell, which she provided, to Resident #290. On 10/8/19 at approximately 5:00 p.m., OSM #3 the maintenance director, was observed entering Resident #290's room. OSM #3 then checked the call lights for Resident #290 and the unoccupied	F 919		

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F 919	Continued From page 52 B bed in Resident #290's room. When OSM #3 tested, the call lights no sound or light was noted. OSM #3 then replaced the cord to the call lights and when OSM #3 pressed the lights, no sound or light was noted. OSM #3 stated he was going to call the [Name of company] to repair Resident #290's call light. An interview was conducted with LPN #1 on 10/8/19 at approximately 5:05 PM. When asked purpose of call lights, LPN #1 stated, "They let us know the resident is asking for something." When asked how staff know a call light is working, LPN #1 stated, "The light and the sound. You see it and hear it." An interview was conducted with CNA #1 on 10/8/19 at approximately 5:10 PM. When asked the purpose of call lights, CNA #1 stated, "They let us know the resident needs something. They help us to respond quicker to the resident." When asked if call lights are part of a safe environment, CNA #1 stated, "Yes, they are." An interview was conducted with LPN #2 on 10/8/19 at approximately 5:15 PM. When asked how the call bell works, LPN #2 stated, "They push the button and the light goes on above the door and sound comes to the nursing station." When asked if there are any preventative checks on the call lights, LPN #2 stated, "Yes, OSM #3 does checks. If a call light isn't working, we fill out a form (electronic work order form) or note it on the 24-hour report." On 10/8/19 at 5:20 PM, ASM (administrative staff member) #1, the administrator, and OSM #3, the maintenance director were informed of the above call light failures and audit results. When asked to	F 919		

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F 919	Continued From page 53 describe the (electronic work order form) form, OSM #3 stated, "It is the electronic work order for repairs." When asked if there is a preventative check system, ASM #1 stated, "Yes, we have two processes in place. We have a pre-admission room checklist that is used for rooms that have been cleaned and are unoccupied and we use a rounding form for occupied rooms." ASM #1, the administrator, provided copies of both forms. The Pre-Admission Room Checklist documented in part, "Call light clipped to be and in working order." The Rounding Form documented in part, "Call bells within reach of patient." OSM #4, the admissions director, was observed conducting rounds on 10/9/19 at 8:50 AM. When asked her role in rounds, OSM #4 stated, "I do daily environmental rounds, we use two forms, one for occupied and one for unoccupied rooms." When asked how call lights were checked, OSM #4 stated, "I push the call light to make sure it comes on." OSM #4 was not observed pushing call light button in occupied or unoccupied rooms. The facility's "Rounds" policy, documents in part, "Purpose- to provide a method that assists the user to monitor and observe systems or processes related to environmental areas." "Guidelines-environmental: safety." On 10/9/19 at approximately 9:30 AM, Resident #290's call light was observed functioning. Resident #290 was interviewed at this time. Resident #290 stated her call light was repaired this morning. The call bell for the unoccupied bed in Resident #290's room was tested and observed too be functional at this time.	F 919		

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F 919	Continued From page 54 No further information was provided prior to exit. References: 1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 111. 2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 54. 3. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 157. 4. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 111. 5. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 176. 6. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 111. 7. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 176. 8. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 259.	F 919		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.	F 947	F 947 The statements made on this plan of correction are not and admission to and not to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. I. Corrective Action CNA #9 #10, #11 completed the required dementia training per policy/ state requirements. II. Identification All residents in the facility have the potential to be affected by the alleged practice.	

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F 947	Continued From page 55 §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and employee record review it was determined that the facility staff failed to ensure that three of ten CNA (certified nursing assistant) records reviewed, received required in-service training for dementia, (CNA [certified nursing assistant] #9, #10, and #11). The findings include: On 10/10/19 at approximately 10:00 a.m., a review of the facility's CNA [certified nursing assistant], annual training was conducted by this surveyor. Review of ten CNA training transcripts revealed three of ten CNAs selected for review did not complete the required training regarding dementia as part of their annual training. Review of CNA # 9's training transcript documented a hire date of 02/15/2016. Further review of the training transcript dated 12/15/17 through 12/15/18 failed to evidence dementia care training." Review of CNA # 10's training transcript documented a hire date of 02/20/2015. Further review of the training transcript dated 02/20/18 through 02/20/19 failed to evidence dementia care training." Review of CNA # 11's training transcript documented a hire date of 09/25/2013. Further review of the training transcript dated 09/25/18 through 09/25/19 failed to evidence dementia	F 947	III. Systematic Changes **All CNA's will be educated and re-educated on ensuring required dementia training is completed per state policy. The Human Resource Director will be educated by Regional Human Resource's Manager to follow up and ensure required CNA's dementia training are completed per state requirements.** IV. Monitoring **Human Resources Director and/or designee will audit CNA records to ensure required dementia training are completed daily x five, weekly x four and then monthly x** two. These audits will be forwarded to the Quality Assurance and Assessment Committee for review to determine if further audits or actions or needed. V. Date of Compliance 11/24/19 RECEIVED NOV 0 7 2019 VDH/OLC	

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	495011	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ALEXANDRIA	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 56 care training." On 10/10/19 at 2:10 p.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing regarding the CNA's annual training. ASM # 2 stated, "The training was assigned but it was not completed. Human resources reviews the training quarterly and brings it up in the morning meeting and lets the department heads know who needs to complete the training. The department heads let their staff know who needs to complete training." On 10/10/19 at 4:30 p.m., an interview was conducted with OSM [other staff member] # 8, director of human resources. OSM # 8 stated that she has only been at the facility for two months. When asked about monitoring CNA's annual training, OSM #8 stated, that she "would be doing monthly tracking and that the corporate office would also be tracking and sending monthly emails of staff who need to complete training." On 10/10/19 at approximately 4:10 p.m., ASM [administrative staff member] # 1, the administrator and ASM # 2, director of nursing and ASM # 3, quality assurance consultant were made aware of the findings. No further information was provided prior to exit.	F 947		