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| COLONNADES HEALTH CARE CENTER | 100 COLONNADES HILL DRIVE CHARLOTTESVILLE, VA 22901 |

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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 02/04/2020 through 02/06/2020. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 02/04/2020 through 02/06/2020. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow.<br><br>The census in this 34 certified bed facility was 28 at the time of the survey. The survey sample consisted of 12 current Resident reviews and 3 closed record reviews. | F 000 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow physician orders for | F 684 | | |

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

LNHA — 2/24/2020

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

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| F 684 | Continued From page 1<br>one of 15 residents in the survey sample, Resident #72; and failed to provide care and services to promote healing of a surgical wound for one of 15 residents in the survey sample, Resident #73.<br><br>The findings include:<br><br>1. Resident #72 was admitted to the facility on 1/27/20 with diagnoses that included chronic kidney disease, atrial fibrillation, high blood pressure, cerebral infarction, congestive heart failure and cognitive communication deficit. The minimum data set (MDS) dated 1/28/20 assessed Resident #72 as cognitively intact.<br><br>On 2/5/20 at 7:53 a.m., licensed practical nurse (LPN #1) was observed administering medications to Resident #72. Among the medicines administered was a 17 gram dose (one capful) of polyethylene glycol powder mixed into a cup of water.<br><br>Resident #72's clinical record documented a physician's order dated 1/27/20 for polyethylene glycol powder 8.5 mg (milligrams) to be administered once per day for constipation. Resident #72's admission orders from the hospital dated 1/27/20 documented polyethylene glycol 8.5 grams (1/2 capful) each day for constipation<br><br>On 2/5/20 at 10:00 a.m., LPN #1 was interviewed about the 17 gram dose given to Resident #72 and the conflicting dosages documented for the polyethylene glycol. LPN #1 reviewed the orders and stated the resident was ordered polyethylene glycol 8.5 grams each day upon admission. LPN #1 stated the resident should have been given 1/2 | F 684 | | |

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| F 684 | Continued From page 2<br>capful dose (8.5 grams) of polyethylene glycol powder instead of the one capful (17 grams) dose. LPN #1 stated the admission order for Resident #72's polyethylene glycol was entered into the computerized record with the wrong dosage.<br><br>This finding was reviewed with the administrator and director of nursing during a meeting on 2/5/20 at 4:45 p.m.<br><br>2. Resident #73 was admitted to the facility on 1/24/20 with diagnoses that included amputation of right great toe, amputation of second left toe, peripheral vascular disease, pancreatic cancer, osteomyelitis, diabetes, gastroesophageal reflux, high blood pressure and anemia. The minimum data set (MDS) dated 1/27/20 assessed Resident #73 as cognitively intact.<br><br>On 2/5/20 at 11:30 a.m., with permission of Resident #73, licensed practical nurse (LPN #1) was observed changing dressings to surgical wounds on the resident's right great toe and left second toe. After preparing supplies, LPN #1 washed her hands and put on gloves. LPN #1 removed the resident's socks and Ace wraps from both feet and then cut off the soiled gauze dressing from the right foot. LPN #1 put on a clean pair of gloves, applied normal saline to the wound and then removed the soiled dressing that was slightly stuck to the right great toe wound. LPN #1 discarded the old dressing, put on a clean pair of gloves and then cleansed the right great toe wound with saline and gauze. LPN #1 applied saline to a gauze pad, placed the new dressing on the wound, covered the wound with a gauze pad, applied Kling wrap and replaced the Ace wrap and sock onto the right foot. LPN #1 | F 684 |  | |

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| F 684 | Continued From page 3 | F 684 | | |

put on a clean pair of gloves and removed the soiled dressing on the resident's left foot. LPN #1 put on new gloves and cleansed the 2nd toe wound with saline and clean gauze. LPN #1 applied new gloves and then applied the wet saline dressing to the left toe wound, covered the wound with a gauze pad and Kling wrap. LPN #1 replaced the Ace wrap and the sock on the left foot. LPN #1 then took off her gloves, discarded supplies and washed her hands.

During the dressing changes, LPN #1 performed no hand hygiene after removing the soiled dressings and prior to cleansing and applying clean dressings on both feet. There was no hand hygiene performed after any of the glove changes and no hand hygiene performed after completing the dressing on the right foot and prior to starting the dressing change on the left foot.

On 2/5/20 at 11:51 a.m., LPN #1 was interviewed about hand hygiene during the dressing changes. LPN #1 stated she washed hands before she started and after finishing the dressing changes. LPN #1 stated, "I should have done handwashing between the feet." LPN #1 stated she was not sure if she was supposed to perform hand hygiene when she changed gloves.

On 2/5/20 at 2:15 p.m., the director of nursing (DON) was interviewed about lack of hand hygiene during the Resident #73's dressing changes. The DON stated nurses were expected to wash hands after removing gloves and should perform hand hygiene after removing dirty dressings and prior to applying clean dressings.

The facility's performance checklist for a dressing change (2018) documented a requirement for

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| F 684 | Continued From page 4<br>hand hygiene after each glove removal and prior to cleansing and applying clean dressings to a wound.<br><br>This finding was reviewed with the administrator and director of nursing during a meeting on 2/5/20 at 4:45 p.m. | F 684 | | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure proper wheelchair positioning for one of 15 residents in the survey sample, Resident #15. An occupational therapist placed a purple exercise band around Resident #15's right leg and tied the exercise band to the extended leg rest of the wheelchair. | F 688 | | |

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| F 688 | Continued From page 5<br><br>The findings include:<br><br>Resident #15 was admitted to the facility on 01/13/2020 with diagnoses that included schizophrenia, fracture of right femur, with routine healing, difficulty walking, muscle weakness, hypertension, and acute embolism/thrombosis of deep veins right lower extremity. The most recent minimum data set (MDS) dated 1/16/2020, which was the 5-day admission assessment assessed Resident #15 as severely impaired for daily decision making with a score of 4 out of 15. Under section G - Functional Status the MDS assessed Resident #15 as requiring extensive assistance, with two person physical assistance for bed mobility, transfers, dressing and toileting; extensive assistance with one person physical assistance for locomotion, hygiene, and bathing; and supervision with one person physical assistance for eating. Resident #15 was assessed with impaired lower extremity range of motion on one side (right).<br><br>Resident #15's clinical record was reviewed on 02/04/2020. Observed in the progress notes was the following notes:<br><br>"1/21/2020 22:07. Guest was observed to be sitting in her w/c (wheelchair) in the living room with her right (surg.) (surgery) leg affixed on the elevated and extended leg rest. Guest was watching television w/o (without) any s/sx's (signs/symptoms) of distress. Leg was affixed with the use of a rubber purple strap. Therapy was notified and OT (occupational therapy) reported using strap to help maintain positioning of guests leg. No s/sx's of trauma was observed to extremity. Hip/Leg is guests operative side and | F 688 | | |

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| F 688 | Continued From page 6<br>extremity has been bruised s/p (status post) surgery, no additional bruising observed. RP/MD (responsible party/medical director) notified. Leg will be monitored x72 hrs (hours)."<br><br>"1/22/2020 06.00. Right leg checked. Guest complained of pain at surgery site. Denied any other comfort in that leg. No swelling or bruising noted from strap used in positioning yesterday."<br><br>Observed on the care plan was the following:<br><br>"Focus: RESOLVED: Right leg tied to leg rest with rubber therapy band to keep leg on leg rest. Goal: RESOLVED: Right leg will not have injury r/t (related to) being tied to leg rest with rubber therapy band. Interventions: RESOLVED: Check her leg every shift for any injury noted to right leg r/t being tied to leg rest by rubber therapy band. Date Initiated: 01/22/2020. Revision: 02/04/2020. Resolved: 02/04/2020."<br><br>A review of Resident #15's physician orders did not document physician orders for the rubber therapy band.<br><br>On 02/04/2020 during the lunch meal observation, Resident #15 was observed seated in the dining room in the wheelchair with leg rests eating lunch. On 02/05/2020 at 8:00 a.m., Resident #15 was observed seated in the wheelchair with leg rests in the common area on the unit.<br><br>On 02/05/2020 at 8:13 a.m., the certified nursing assistant (CNA #1) who routinely provided care for Resident #15 was interviewed regarding concerns for positioning. CNA #1 stated she had not observed any type of strap or band being | F 688 | | |

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| F 688 | Continued From page 7<br>used on Resident #15's leg. CNA #1 continued and stated the resident uses the leg rests on her wheelchair and there were no concerns of positioning with the resident and staff transported the resident in the wheelchair.<br><br>On 02/05/2020 at 4:00 p.m., the director or nursing (DON) was asked for a copy of the incident report for the above incident. The DON stated this was an isolated incident and on the day of the incident she was standing at the medication cart with other staff and overhead a certified nursing assistant (CNA) make a statement to the charge nurse that something was attached to Resident #15's leg. The DON stated she observed Resident #15 sitting in the wheelchair in the common area on the unit. The DON was asked what did she observe with the resident. The DON continued and stated she observed a rubber purple exercise strap tied to the resident's right leg and the strap was then tied to the extended leg rest on the wheelchair. The DON continued and stated she immediately removed the strap and advised the charge nurse to assess Resident #15 for signs of injury. The DON stated she notified the therapy department manager and after completing the investigation, it was determined the OT staff placed the strap on Resident #15's leg and affixed it to the wheelchair because of concerns that the resident's leg/foot was slipping off the extended leg rest.<br><br>A review of the incident report documented on 1/21/2020 at 3:30 p.m., Resident #15 was observed with a purple strap holding the resident's leg in place on the extended wheelchair. The incident report documented the OT staff stated they had applied the strap for positioning to keep the leg affixed on the | F 688 | | |

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| F 688 | Continued From page 8<br>extending/elevated wheelchair leg. The report documented the strap was immediately removed and Resident #15 was assessed. The report documented the doctor and responsible party were notified of the incident. Ongoing assessment of Resident #15 right leg for 72 hours did not document any signs or symptoms of injury.<br><br>On 02/05/2020 at 4:10 p.m., the OT staff (OS #1) was interviewed regarding the incident. OS #1 stated on 1/21/2020 while working with Resident #15, she observed the resident's right leg sliding off the extended leg rest. OS #1 stated after completing the therapy session she transported the resident to the living room on the unit. OS #1 stated she observed Resident #15's right leg appeared to drift off the extended leg rest. OS #1 stated "I told [Resident #15] I was concerned her leg was weak and was going to slide off the extended leg rest." OS #1 continued and stated, "[Resident #15] said she was too." OS #1 stated, "I asked [Resident #15] if it was okay for me to place some kind of strap on her leg to keep her leg on the extended leg rest and she [Resident #15] said yes." OS #1 continued and stated "I should have found another type of positioning device like a leg buddy, but I just got busy and did not follow-up with the resident." OS #1 was asked if the rubber therapy band had been used as part of the therapy session with Resident #15. OS #1 stated "no, I got the band after I completed the session and observed the resident's leg sliding of the foot extended leg rest." OS #1 was asked to describe where the strap was affixed to Resident #15's leg. OS #1 stated, "I tied the band loosely around the resident's right knee and then tied the band to the cushion of the elevated leg rest of the wheelchair." OS #1 was asked if | F 688 | | |

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| F 688 | Continued From page 9<br>nursing was notified of the concern and that the band had been affixed to the resident's leg and wheelchair. OS #1 stated, "no." OS #1 was asked if she reviewed or observed if Resident #15 was able to remove the band. OS #1 stated, "no, I did not review with [Resident #15] if she was able to remove the band."<br><br>On 02/05/2020 at 4:20 p.m., the therapy department manager (OS #2) was interviewed. OS #2 stated OS #1 should have used a more appropriate positioning device from the therapy department and this was an isolated incident. OS #2 stated OS #1 received education on proper positioning.<br><br>The charge nurse who completed the incident report was not available for interview during the survey.<br><br>The above findings were reviewed with the administrator and director of nursing on 02/05/2020 at 4:45 p.m.<br><br>No additional information was provided to the survey team prior to exit on 02/06/2020 at 11:00 a.m. | F 688 | | |
| F 700 SS=E | Bedrails<br>CFR(s): 483.25(n)(1)-(4)<br><br>§483.25(n) Bed Rails.<br>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. | F 700 | | |

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| F 700 | Continued From page 10<br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review, the facility staff failed to attempt alternatives, identify risks/benefits and obtain informed consent prior to use of the bed rails for five of 36 residents in the survey sample, Resident #2, #12, #1, #10, #11.<br><br>The findings include:<br><br>1. Resident #2 was admitted to the facility on 11/14/16 with diagnoses that included Alzheimer's Disease, spinal stenosis, chronic kidney disease - stage 3, hypertension, depression and hemiparesis/hemiplegia. The most recent minimum data set (MDS) dated 12/1/19 which was a quarterly assessment, assessed Resident #2 as severely impaired for daily decision making with a score of 3 out of 15. Under section G - Functional Status, the MDS assessed Resident #2 as requiring extensive assistance, with one person physical assistance for bed mobility and total dependent with two persona physical assistance for transfers. | F 700 | | |

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| F 700 | Continued From page 11<br><br>On 02/04/20 at 2:10 p.m., Resident #2 was observed in bed sleep with short length bed rails in the raised position on both sides of the bed, near the head of the bed. Resident #2 was observed in bed again on 02/05/20 at 11:00 a.m., with the bed rails in the up position.<br><br>Resident #2's clinical record was reviewed on 02/05/2020. Observed on the physician orders was the following order: "Guest would benefit from bilateral bed enablers to assist with bed mobility, position and transfers. Order date 11/14/2016."<br><br>Observed on Resident #2's care plans was the following: "FOCUS: Bed mobility (created 04/20/2018). GOAL: I will maintain current level of function in bed mobility through the next review date. Interventions:....I require the use of bilateral enablers to assist me with my bed mobility. Remind and encourage me to use my enabler/device when repositioning in bed...."<br><br>On 02/05/2020 at 11:15 a.m., the certified nursing assistant (CNA #1) who routinely provided care for Resident #2 was interviewed about the resident's use of the grab bars. CNA #1 stated, "no, [Resident #2] can not use the rails at all because of her hand contractures."<br><br>A review of Resident #2's clinical record documented the most recent bed mobility assessment on 04/14/2019 which was an annual assessment. Under the bed mobility section, Resident #2 was assessed as total dependent for bed mobility and #4 of the section documented: "Bed Mobility assistive devices needed. No". | F 700 | | |

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| F 700 | Continued From page 12<br>Resident #2's clinical record did not document an assessment for entrapment risks related to the bed rails, prior alternatives attempts to the bed rails, no identified risks/benefits of the rails and no informed consent from the responsible party.<br><br>2. Resident #12 was admitted to the facility on 12/16/14 with diagnoses that included hospice encounter, Alzheimer's disease, muscle weakness, chronic obstructive pulmonary disease (COPD), and abnormal posture. The most recent MDS dated 01/20/2020 which was a significant change, assessed Resident #12 as severely impaired for daily decision making with a score of 3 out of 15. Under section G - Functional Status, the MDS assessed Resident #12 as total dependent for bed mobility, with one person physical assistance and total dependent for transfer with hoyer lift, requiring two person physical assistance.<br><br>On 02/05/20 at 11:00 at Resident #12 was observed in the bed sleep with the short length bed rails in the raised position on both sides of the bed, near the head of the bed.<br><br>Resident #12's clinical record was reviewed on 02/05/2020. Observed on the physician orders was the following order: "Guest would benefit from bilateral enabling devices to assist with bed mobility, positioning and transfers. Order date 11/04/2015."<br><br>Observed on the care plans was the following: "FOCUS: Bed mobility. (created 08/27/2018). GOAL: I will maintain current level of function in bed mobility through the next review date. Interventions:.....Bilateral enablers on her bed | F 700 | | |

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| F 700 | Continued From page 13<br>(initiated 01/23/2020). The resident is dependent for bed mobility (initiated 01/23/2020)....."<br><br>On 02/05/2020 at 11:15 a.m., the certified nursing assistant (CNA #1) who routinely provided care for Resident #12 was interviewed about the resident's use of the grab bars. CNA #1 stated, "no, [Resident #12] does not use the bed rails at all." CNA #1 stated the facility used the hoyer lift for transfers for Resident #12 and the resident was not able to turn and reposition in bed alone.<br><br>A review of Resident #12's clinical record documented the most recent bed mobility assessment on 01/20/2020 which was a significant change assessment. Under the bed mobility section, Resident #12 was assessed as total dependent for bed mobility and #4 of the section documented: "Bed Mobility assistive devices needed. No".<br><br>Resident #12's clinical record did not document an assessment for entrapment risks related to the bed rails, prior alternatives attempts to the bed rails, no identified risks/benefits of the rails and no informed consent from the responsible party.<br><br>On 02/05/2020 at 11:10 a.m., the administrator and director of nursing (DON) were interviewed regarding the bed rail assessments, alternatives and benefits and if consents had been obtained for use of the bed rails. The DON stated they facility did not have bed rails and the beds were purchased with the assist bars already in place and the rails could not be lowered or raised. The administrator stated all the beds in the facility had the pre-installed rails and their company did not consider the assist bars as bed rails. | F 700 | | |

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| F 700 | Continued From page 14<br><br>On 02/05/2020 at 1:30 p.m., the DON returned to the conference room and stated the bed rail assessments were completed as part of the "Service Evaluation and Health Assessment" under the bed mobility section of the assessment. The DON stated the assessments were completed during the admission, annual and significant change assessments. The DON stated the social worker would have the consents since that was part of the admission package.<br><br>On 02/05/2020 at 1:45 p.m., the social worker (OS #3) was interviewed regarding the bed rail consent forms. OS #3 provided a copy of a form titled "Acknowledgement and Consent For The Use Of A Transfer Assistive Device." OS #3 stated this form was part of the admission contract and reviewed with skilled residents and/or the responsible party during the admission. OS #3 stated she had no informed consent for Resident #2, #12 or any of the long term residents.<br><br>These findings were reviewed with the Administrator and DON during a meeting on 02/05/2020 at 4:45 p.m.<br><br>No additional information was provided to the survey team prior to exit on 02/06/2020 at 11:00 a.m.<br><br>3. Resident #1 was admitted to the facility on 5/10/18 with diagnoses that included Alzheimer's dementia, osteoporosis, osteoarthritis, major depressive disorder and anxiety. The minimum data set (MDS) dated 11/6/19 assessed Resident #1 with severely impaired cognitive skills and as requiring the extensive assistance of one person | F 700 | | |

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| F 700 | Continued From page 15<br>for bed mobility and two people for transfers.<br><br>On 2/4/20 at 2:50 p.m., Resident #1 was observed in bed. Short bed rails were in the raised position on both sides of the bed, near the head. The resident was observed in bed again on 2/4/20 with the short bed rails in the raised position on both sides of the bed.<br><br>Resident #1's clinical record documented a nursing assessment dated 5/2/19 listing the resident had severely impaired cognitive skills, limited range of motion of upper and lower extremities and stating a "bed enabler" was required for bed mobility. Resident #1's plan of care (revised 1/23/20) documented the resident required extensive assistance from staff members for bed mobility and transfers. Care plan interventions listed, "I require the use of bilateral enablers to assist me with my bed mobility."<br><br>Resident #1's clinical record documented no assessment for entrapment risks related to rail use, no prior attempted alternatives to the bed rails, no identified risks/benefits of the rails and no informed consent for the bed rails from the resident's responsible party.<br><br>4. Resident #10 was admitted to the facility on 4/22/19 with diagnoses that included dementia, seizures, peripheral neuropathy, constipation, hypothyroidism, pulmonary edema, atrial fibrillation, congestive heart failure and chronic kidney disease. The minimum data set (MDS) dated 1/8/20 assessed Resident #10 with severely impaired cognitive skills and as requiring the extensive assistance of two people for bed mobility and total dependence off two people for | F 700 | | |

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| F 700 | Continued From page 16<br>transfers.<br><br>On 2/4/20 at 2:50 p.m., Resident#10 was observed in a low bed with short bed rails in the up position on both sides of the bed, near the head. A fall mat was in the floor by the bed. Resident #10 was observed again on 2/5/20 at 11:00 a.m. in bed with raised bed rails and a protective mat in the floor.<br><br>Resident #10's clinical record documented a physician's order dated 4/22/19 to "Turn and reposition every 2 hours as tolerated." A nursing assessment dated 4/22/19 documented the resident required extensive assistance of staff for bed mobility and did not require the use of bed assistive devices. The resident's plan of care (revised 10/22/19) documented the resident had impaired bed mobility and stated, "I require the use of bilateral enablers to assist me with my bed mobility and transfers."<br><br>Resident #10's clinical record documented no assessment for entrapment risks related to rail use, no prior attempted alternatives to the bed rails, no identified risks/benefits of the rails and no informed consent for the bed rails from the resident's responsible party.<br><br>5. Resident #11 was admitted to the facility on 3/25/16 with diagnoses that included Alzheimer's dementia, edema, atherosclerotic heart disease, hypothyroidism, anemia, osteoarthritis and age-related debility. The minimum data set (MDS) dated 1/8/20 assessed Resident #11 with severely impaired cognitive skills and as requiring extensive assistance of one person for bed mobility and total dependence of two people for transfers. | F 700 | | |

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| F 700 | Continued From page 17<br><br>On 2/4/20 at 2:53 p.m., Resident #11 was observed in a low bed with short bed rails in the up position on both sides of the bed, near the head. The resident had protective sleeves on both forearms. Resident #11 was observed again on 2/5/20 at 10:59 a.m. in bed with raised bed rails.<br><br>Resident #11's clinical record documented a physician's order dated 3/25/16 stating, "Guest will benefit from bilateral enabling devices to assist with bed mobility and transfers." Another physician's order dated 8/15/19 documented, "Turn and Reposition Q2H [every two hours] while in bed..." A nursing assessment dated 10/18/19 documented the resident had advanced dementia, was totally dependent on staff for bed mobility and did not require the use of a bed mobility device. Resident #11's plan of care (revised 10/23/19) documented, "I require the use of enablers on my bed to assist me with my bed mobility."<br><br>Resident #11's clinical record documented no assessment for entrapment risks related to rail use, no prior attempted alternatives to the bed rails, no identified risks/benefits of the rails and no informed consent for the bed rails from the resident's responsible party.<br><br>On 2/5/20 at 11:10 a.m., the administrator and director of nursing (DON) were interviewed about bed rails in use with Residents #1, #10 and #11. The DON stated, "We don't have bed rails." The DON stated the beds were purchased with "assist bars" already in place and the rails could not be raised and lowered. The administrator stated all the beds in the facility had the pre-installed rails | F 700 | | |

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| F 700 | Continued From page 18<br>and their company did not consider the assist bars as bed rails.<br><br>On 2/5/20 at 1:48 p.m., the social worker (other staff #3) was interviewed about any informed consents from residents and/or representative about bed rails use. The social worker stated the admission contract had a document about side rail risks and this was reviewed with skilled patients at the time of admission. The social worker stated she had no informed consents for Residents #1, #10, #11 or any of the long-term care residents.<br><br>There was no other information presented of individualized resident assessments regarding entrapment risks, identified risks/benefits of rails, any attempted alternatives to rails or informed consents regarding bed rail use.<br><br>These findings were reviewed with the administrator and director of nursing during a meeting on 2/5/20 at 4:45 p.m. | F 700 | | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, | F 755 | | |

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| F 755 | Continued From page 19<br>dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview and clinical record review, the facility staff failed to ensure a medication was available for administration for one of 15 residents in the survey sample. Resident #73's pain medication oxycodone was not available for administration as ordered by the physician.<br><br>The findings include<br><br>Resident #73 was admitted to the facility on 1/24/20 with diagnoses that included amputation of right great toe, amputation of second left toe, peripheral vascular disease, pancreatic cancer, osteomyelitis, diabetes, gastroesophageal reflux, high blood pressure and anemia. The minimum data set (MDS) dated 1/27/20 assessed Resident #73 as cognitively intact. | F 755 | | |

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| F 755 | Continued From page 20<br><br>On 2/5/20 at 10:42 a.m., Resident #73 was interviewed about quality care in the facility. Resident #73 stated he was "in intense pain" when he arrived at the facility on the evening of 1/24/20. Resident #73 stated he arrived at the facility before 7:00 p.m. and was told the oxycodone pain medication was not available. Resident #73 stated he had "several hours of pain" on 1/24/20 and the facility was unable to acquire his prescribed oxycodone from the pharmacy. Resident #73 stated the nurses reported to him they made multiple attempts to get the medication from pharmacy but had not been successful. Resident #73 stated the nurses did not have access to the oxycodone until around 10:30 a.m. the next morning on 1/25/20.<br><br>Resident #73's clinical record documented the resident arrived at the facility on 1/24/20 at 6:00 p.m. Resident #73's clinical record documented a physician's order for oxycodone 5 mg (milligrams) to be administered every four hours as needed for pain.<br><br>A nursing note dated 1/25/20 at 7:13 a.m. documented, "3 - 11 Nurse...has passed along in report that she called Pharmacy multiple times, as well as faxed off scripts for Resident Oxy [oxycodone] and IV Antibiotics. Pharm [pharmacy] has stated they have not received the fax each time. She tried different machines, and numbers, as did I when I came on to the shift. Resident was informed of the situation..."<br><br>On 2/5/20 at 2:55 p.m., licensed practical nurse (LPN #1) that cared for Resident #73 on 1/25/20 was interviewed about the availability of the oxycodone. LPN #1 stated the evening nurse | F 755 | | |

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| F 755 | Continued From page 21<br>reported she tried multiple times to get the script to pharmacy and each time pharmacy reported they did not receive the fax. LPN #1 stated she called the pharmacy three times on the morning of 1/25/20 to get the medication or a code to access the emergency supply of oxycodone located at the facility. LPN #1 stated the pharmacy reported each time they did not have the faxed script even though it was faxed multiple times with error. LPN #1 stated that around 10:30 a.m. on 1/25/20 the pharmacy finally stated they had the fax and the medication was accessed from the emergency supply. LPN #2 stated she had frequent issues with the pharmacy providing controlled medications. LPN #2 stated she often faxed scripts for residents to the pharmacy with delays in getting the medication because pharmacy reported they did not get the fax.<br><br>On 2/5/20 at 3:00 p.m., registered nurse (RN) #2 that worked on Resident #73's living unit was interviewed about problems with availability of controlled medications from the pharmacy. RN #2 stated, "We have lots of problems with scripts." RN #2 stated she often faxed scripts multiple times to the pharmacy with pharmacy delaying delivery or access to the controlled medications because they report they did not get the faxed script.<br><br>On 2/5/20 at 3:25 p.m., the director of nursing (DON) was interviewed about Resident #73's unavailable oxycodone. The DON stated the admitting nursing faxed the script multiple times to the pharmacy and pharmacy failed to provide the access code and/or medication reporting they did not get the script. The DON stated the script was provided with Resident #73's admission | F 755 | | |

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| F 755 | Continued From page 22<br>orders from the hospital and the delay in getting the oxycodone was due to the facility's pharmacy.<br><br>On 2/5/20 at 4:30 p.m., the facility's registered pharmacist (other staff #5) was interviewed by telephone about Resident #73's unavailable oxycodone. After researching, the pharmacist stated the signed script was received by pharmacy on 1/25/20 at 9:11 a.m. and the pharmacy received the request for the emergency access code on 1/25/20 at 10:00 a.m. The pharmacist stated the pharmacy received no faxed scripts or requests for the oxycodone on 1/24/20.<br><br>On 2/6/20 at 7:36 a.m., the DON presented copies of the faxed scripts to the pharmacy for Resident #73, all indicating faxes were sent/received without error. There were five faxed scripts for Resident #73's oxycodone on the evening of 1/24/20. The faxes were stamped 1/24/20 at the following times: 6:00 p.m., 7:33 p.m., 7:57 p.m., 9:20 p.m. and 10:12 p.m.<br><br>This finding was reviewed with the administrator and director of nursing during a meeting on 2/5/20 at 4:45 p.m. | F 755 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. | F 761 | | |

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| F 761 | Continued From page 23<br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, facility document review and staff interview, the facility staff failed to ensure an opened vial of insulin, stored and available for use in the facility's only medication room, was properly labeled. A vial of Lantus insulin no label or indication of when the vial was opened or when to discard.<br><br>The findings include:<br><br>On 2/5/20 at 10:11 a.m., accompanied by the director of nursing (DON), the facility's only medication room was inspected. Stored in the medication refrigerator was an opened vial of Lantus insulin. The vial was labeled for a current resident and had a pharmacy sticker with a space for date opened and/or discard date. There was no indication of when the vial was opened or when to discard the insulin. The DON was interviewed at the time of the observation about | F 761 | | |

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| | 495254 | A. BUILDING _____ B. WING _____ | 02/06/2020 |

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| COLONNADES HEALTH CARE CENTER | 100 COLONNADES HILL DRIVE CHARLOTTESVILLE, VA 22901 |

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| F 761 | Continued From page 24<br>the unlabeled insulin. The DON stated the nurses usually wrote the date on the insulin vials when opened.<br><br>On 2/5/20 at 10:22 a.m., the DON stated the evening nurse reported she opened the Lantus insulin and realized the resident had insulin pens for use. The DON stated the nurse put the insulin back into the refrigerator and was planning to return the insulin to the pharmacy.<br><br>The facility's policy presented by the DON titled Community Medication Oversight Program (undated) documented, "...All medications are stored according to manufacturer's recommendations..."<br><br>The Lantus manufacturer's safe storage instructions documented, "The Lantus vials you are using should be thrown away after 28 days, even if it still has insulin left in it..." (1)<br><br>This finding was reviewed with the administrator and director of nursing during a meeting on 2/5/20 at 4:45 p.m.<br><br>(1) How to Inject Lantus with a Vial and Syringe. December 2019. Sanofi-Aventis US LLC. 2/6/2020. https://www.lantus.com | F 761 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent | F 842 | | |

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| F 842 | Continued From page 25<br>agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained | F 842 | | |

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| F 842 | Continued From page 26<br>for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review, the facility staff failed to ensure an accurate clinical record for one of 15 residents in the survey sample. Resident #72's clinical record documented an inaccurate dosage for the medication polyethylene glycol.<br><br>The findings include:<br><br>Resident #72 was admitted to the facility on 1/27/20 with diagnoses that included chronic kidney disease, atrial fibrillation, high blood pressure, cerebral infarction, congestive heart failure and cognitive communication deficit. The minimum data set (MDS) dated 1/28/20 assessed Resident #72 as cognitively intact.<br><br>On 2/5/20 at 7:53 a.m., licensed practical nurse | F 842 | | |

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| F 842 | Continued From page 27<br>(LPN #1) was observed administering medications to Resident #72. Among the medicines administered was a 17 gram dose (one capful) of polyethylene glycol powder mixed into a cup of water.<br><br>Resident #72's clinical record documented conflicting doses for the polyethylene glycol. A physician's order dated 1/27/20 documented polyethylene glycol powder 8.5 mg (milligrams) to be administered once per day for constipation. Resident #72's admission orders from the hospital dated 1/27/20 documented polyethylene glycol 8.5 grams (1/2 capful) each day for constipation.<br><br>On 2/5/20 at 10:00 a.m., LPN #1 was interviewed about the conflicting dosages documented for the polyethylene glycol. LPN #1 reviewed the orders and stated the resident was ordered polyethylene glycol 8.5 grams (1/2 capful) each day upon admission. LPN #1 stated the admission order for Resident #72's polyethylene glycol was entered into the computerized record with the wrong dosage.<br><br>On 2/5/20 at 4:51 p.m., the director of nursing (DON) was interviewed about the inaccurate order for Resident #72's polyethylene glycol. The DON stated the nurse admitting the resident entered the order into the computerized clinical record. The DON stated she reviewed orders for new admissions but the error must have been missed.<br><br>This finding was reviewed with the administrator and director of nursing during a meeting on 2/5/20 at 4:45 p.m. | F 842 | | |

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| F 880 | Continued From page 28 | F 880 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; | F 880 | | |

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| F 880 | Continued From page 29<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow infection control practices for hand hygiene during a surgical wound dressing change for one of 15 residents in the survey sample, Resident #73.<br><br>Findings include: | F 880 | | |

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| F 880 | Continued From page 30<br>Resident #73 was admitted to the facility on 1/24/20 with diagnoses that included amputation of right great toe, amputation of second left toe, peripheral vascular disease, pancreatic cancer, osteomyelitis, diabetes, gastroesophageal reflux, high blood pressure and anemia. The minimum data set (MDS) dated 1/27/20 assessed Resident #73 as cognitively intact.<br><br>On 2/5/20 at 11:30 a.m., with permission of Resident #73, licensed practical nurse (LPN #1) was observed changing dressings to surgical wounds on the resident's right great toe and left second toe. After preparing supplies, LPN #1 washed her hands and put on gloves. LPN #1 removed the resident's socks and Ace wraps from both feet and then cut off the soiled gauze dressing from the right foot. LPN #1 put on a clean pair of gloves, applied normal saline to the wound and then removed the soiled dressing that was slightly stuck to the right great toe wound. LPN #1 discarded the old dressing, put on a clean pair of gloves and then cleansed the right great toe wound with saline and gauze. LPN #1 applied saline to a gauze pad, placed the new dressing on the wound, covered the wound with a gauze pad, applied Kling wrap and replaced the Ace wrap and sock onto the right foot. LPN #1 put on a clean pair of gloves and removed the soiled dressing on the resident's left foot. LPN #1 put on new gloves and cleansed the 2nd toe wound with saline and clean gauze. LPN #1 applied new gloves and then applied the wet saline dressing to the left toe wound, covered the wound with a gauze pad and Kling wrap. LPN #1 replaced the Ace wrap and the sock on the left foot. LPN #1 then took off her gloves, discarded supplies and washed her hands. | F 880 |  | |

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| F 880 | Continued From page 31<br>During the dressing changes, LPN #1 performed no hand hygiene after removing the soiled dressings and prior to cleansing and applying clean dressings on both feet. There was no hand hygiene performed after any of the glove changes and no hand hygiene performed after completing the dressing on the right foot and prior to starting the dressing change on the left foot.<br><br>On 2/5/20 at 11:51 a.m., LPN #1 was interviewed about hand hygiene during the dressing changes. LPN #1 stated she washed hands before she started and after finishing the dressing changes. LPN #1 stated, "I should have done handwashing between the feet." LPN #1 stated she was not sure if she was supposed to perform hand hygiene when she changed gloves.<br><br>On 2/5/20 at 2:15 p.m., the director of nursing (DON) was interviewed about lack of hand hygiene during the Resident #73's dressing changes. The DON stated nurses were expected to wash hands after removing gloves and should perform hand hygiene after removing dirty dressings and prior to applying clean dressings.<br><br>The facility's policy titled Infection Prevention & Control Program (August 2018) documented, "Hand hygiene means cleaning your hands with soap and water, antiseptic hand wash, antiseptic hand rub...Clean hands are the single most important factor in preventing the spread of pathogens and antibiotic resistance in healthcare setting...Key situations where hand hygiene should be performed include...Before and after direct contact with a resident's intact skin...After contact with blood, body fluids or contaminated surfaces...If hands will be moving from a contaminated-body site to a clean-body site | F 880 | | |

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| F 880 | Continued From page 32<br>during resident care...After removal of personal protective equipment (PPE)..."<br><br>The facility's performance checklist for a dressing change (2018) documented a requirement for hand hygiene after each glove removal and prior to cleansing and applying clean dressings to a wound.<br><br>This finding was reviewed with the administrator and director of nursing during a meeting on 2/5/20 at 4:45 p.m. | F 880 | | |

# Sunrise Senior Living
# Plan of Correction Template

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**Name of Community:** The Colonnades
**Address:** 100 Colonnades Hill Drive Charlottesville, VA 22901
**License number:** 495254
**Inspection date(s):** 2/4/20-2/6/20
**Name and Title of Sunrise Representative Signing the Plan of Correction:**
Jennifer Crouch, Licensed Nursing Home Administrator
**Signature of Sunrise Representative:** J Crouch, LNHA
**Date of Submission:** **2/21/2020**

| Regulation | Target Date by Which Correction will be completed | Plan of Correction |
|---|---|---|
| F 684 Quality of Care CFR(s): 483.25 | 3/13/2020 | **A. With respect to the specific resident/situation cited:**<br><br>Resident #72 experienced no negative outcomes as a result of the Polyethylene glycol powder that was administered by LPN #1.<br><br>The physician was contacted by LPN #1 and clarified the order and the physician issued no new orders.<br><br>Resident #73 was observed and assessed for 72 hours following the dressing change; and experienced no negative outcomes as a result of gloves being changed frequently with no hand washing between changes. |
| | | **B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:**<br><br>On 2/5/20, DNS and RAC reviewed orders on the residents including residents admitted within the last 24 hours and checked to confirm accuracy in the EMARs.<br>No other issues were identified.<br><br>On 2/5/20 refresher In-service was completed by the DNS for LPN #1 on appropriate treatment and wound care procedures, |



*Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.*

| Regulation | Target Date by Which Correction will be completed | Plan of Correction |
|---|---|---|
| | | including appropriate hand washing during treatments and wound care. |
| | | **C. With respect to what systemic measures have been put into place to address the stated concern:**<br><br>The RN Resident Assessment Coordinator and/or the DNS will conduct random unannounced medication pass observations weekly for 3 months to confirm administration in accordance with physician orders.<br><br>The RN Resident Assessment Coordinator and/or the DNS will conduct random unannounced treatment observations weekly for 3 months to confirm appropriate hand washing and glove usage.<br>The RAC and/or DNS will audit new orders including admissions orders for medication and dosage during the clinical meeting, and confirm the orders are entered correctly in PCC/EMARs.<br><br>Refresher training on the Infection control wellness program was conducted with the nursing staff; including proper hand hygiene and glove usage. The refresher training was conducted by the DNS,<br><br>The DNS or designee will report the results of the weekly audits, med pass observations, treatment observations at the Quality Assurance and Performance Improvement Meetings for 3 months.<br><br>During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period. |





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| Regulation | Target Date by Which Correction will be completed | Plan of Correction |
|---|---|---|
| | | **D. With respect to how the plan of correction will be monitored:**<br><br>The Skilled Nursing Administrator is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. |
| F688 Increase/Prevent Disease in ROM/Mobility CFR(s): 483.25(c) (1)-(3) | 3/13/2020 | **A. With respect to the specific resident/situation cited:**<br><br>Upon observing Resident #15 sitting in her Wheelchair with a purple therapy band tied to her leg and footrest, the band was removed by the DNS<br><br>The physician was notified by the Nurse and issued no new orders.<br><br>Resident #15 was assessed for 72 hours by the Nurse team and no negative outcomes were observed.<br><br>The Therapy Assistant that placed the band received refresher training and a performance improvement plan from the Therapy Director. |
|  | | **B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:**<br><br>Physician orders for positioning, mobility, and assistive devices were reviewed by the DNS and RAC to confirm implementation and understanding by the Care Team.<br><br>Refresher training will be conducted by the DNS and/or RAC for the Care Team regarding |

| Regulation | Target Date by Which Correction will be completed | Plan of Correction |
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| | | following physician orders for positioning, mobility, and assistive devices and reporting any variances or different approaches that are observed to Nursing Leadership.<br>Assessment of resident mobility will continue to be completed on new admissions in conjunction with therapy evaluations.<br><br>If positioning devices are required, the Interdisciplinary Team (IDT) will meet and discuss appropriate interventions. The physician will be contacted for orders, as needed and the assessment of the resident completed and device obtained<br><br>The Care plan will be updated to reflect the appropriate physician ordered mobility or positioning devices.<br><br>The Therapy Director has provided refresher training for the therapy team, regarding adhering to physician orders for positioning and mobility devices and reporting recommendations for improved approaches to the IDT team, prior to applying or testing an approach. |
| | | **C. With respect to what systemic measures have been put into place to address the stated concern:**<br><br>The RN Resident Assessment Coordinator and/or the DNS will conduct random unannounced observations weekly for 3 months of the residents to confirm appropriate device usage per physician order and that there are no unapproved devices in use. Issues that may be identified will be addressed and resolved and refresher training initiated.<br><br>The Therapy Director will be monitoring resident positioning weekly for 3 months during treatments, including making |

| Regulation | Target Date by Which Correction will be completed | Plan of Correction |
|---|---|---|
| | | recommendations to the IDT for changes or additions.<br><br>The DNS or designee will report the results of the observations at the Quality Assurance and Performance Improvement Meetings for 3 months.<br><br>During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period. |
| | | **D. With respect to how the plan of correction will be monitored:**<br><br>The Skilled Nursing Administrator is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. |
| F700 Bedrails CFR(s): 483.25(n)(1)-(4) | 3/13/2020 | **A. With respect to the specific resident/situation cited:**<br><br>Resident #1, #2, #10, #11, and #12 were reassessed for use of bed enablers by the IDT, and their ISPs were updated accordingly.<br><br>The DNS is in the process of obtaining physician orders to discontinue the enablers for Resident #1, #2, #10, #11, and #12.<br><br>The DNS contacted the physicians and the resident representatives of Resident #1, #2, #10, #11, and #12 regarding the removal of the enablers and no concerns were expressed.<br><br>For Residents #1, #2, #10, #11, and #12 the enablers will be removed by the Maintenance Team. |

| Regulation | Target Date by Which Correction will be completed | Plan of Correction |
|---|---|---|
| | | **B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:**<br><br>Current residents have been reassessed by the DNS and/or RAC for the use of bed enablers for turning, positioning and mobility.<br><br>For residents that have been found to be unable to successfully utilize an enabler, the device is in the process of being removed and interventions are being put in place to confirm the resident's safety. The ISPs are in the process of being updated to include these interventions.<br><br>Residents that have been assessed to be able to utilize the bed enablers for turning, positioning and mobility have had their ISPs updated and physician orders and consent confirmed.<br><br>These residents will be reviewed and assessed at a minimum monthly for continued appropriateness for use of enablers, with updated interventions added to the ISPs as needed. |
| | | **C. With respect to what systemic measures have been put into place to address the stated concern:**<br><br>As stated, the current residents have been assessed for appropriate use of bed enablers with care plans interventions in place and removal of devices in process, if needed.<br><br>Residents will continue to be assessed upon admission and at a minimum monthly by the IDT to confirm residents' continued ability to utilize bed enablers safely. The ISP will be updated to reflect resident needs and interventions. |

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| | | The DNS or designee will report the results of the assessments at the Quality Assurance and Performance Improvement Meetings for 3 months.<br><br>During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period. |
| | | **D. With respect to how the plan of correction will be monitored:**<br><br>The Skilled Nursing Administrator is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. |
| F755 Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.25(a)(b)(1)-(3) | 3/13/2020 | **A. With respect to the specific resident/situation cited:**<br><br>The pain medication for Resident #73 was delivered the morning of 1/25/20, and verified and placed on the med cart by the Nurse. Resident #73 was informed of the delivery and the specific order by the Nurse. |
| | | **B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:**<br><br>Physician orders for routine and PRN medications for the prior 30 days were reviewed by the DNS or RAC to confirm delivery and availability on the med carts and/or Omni cell.<br>Issues that were identified were addressed and resolved.<br><br>Training is being conducted by the DNS and/or RAC for the Nurses regarding confirming delivery and availability on the med carts and/or Omni cell and following up with |

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| | | pharmacy orders and deliveries, and reporting issues to the Director of Nursing. |
| | | **C. With respect to what systemic measures have been put into place to address the stated concern:**<br><br>New admissions orders will be reviewed by the DNS or designee and the pharmacy will be notified via a phone call about the new admission orders and the plan to fax the orders to the pharmacy.<br><br>The nurses will make a follow up call after orders are faxed to confirm the pharmacy received the orders, and to confirm scheduled delivery.<br><br>The RN Resident Assessment Coordinator and/or the DNS will conduct random audits of orders sent to the pharmacy and availability in the med carts (and/or Omni cell) weekly for 3 months to confirm.<br>Issues that may be identified will be addressed and resolved.<br><br>The DNS will report the results of the audits at the Quality Assurance and Performance Improvement Meetings for 3 months.<br><br>During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period. |
| RECEIVED<br>FEB 2 8 2020<br>VDH/OLC | | **D. With respect to how the plan of correction will be monitored:**<br><br>The Skilled Nursing Administrator is responsible for confirming implementation and ongoing compliance with the components of |

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| | | this Plan of Correction and addressing and resolving variances that may occur. |
| F761 Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) | 3/13/2020 | **A. With respect to the specific resident/situation cited:**<br><br>Resident #73 did not have a negative outcome from the vial of insulin that was undated in the medication room refrigerator.<br><br>The medication was removed by the Nurse and sent back to the pharmacy on 2/5/2020. |
| | | **B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:**<br><br>On 2/5/2020 the DNS performed a cart audit and a medication room audit to confirm insulin vials were dated and no other discrepancies were identified. |
| | | **C. With respect to what systemic measures have been put into place to address the stated concern:**<br><br>On 2/25/2020, refresher training will be conducted by the DNS on the medication oversight program, with a focus on dating of inulin vials, per manufacturer's recommendations.<br><br>DNS/designee will complete weekly medication audits to confirm dating of insulin vials, weekly for 3 months.<br><br>The DNS will report the results of the audits at the Quality Assurance and Performance Improvement Meetings for 3 months.<br><br>During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period. |

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| | | **D. With respect to how the plan of correction will be monitored:**<br><br>The Skilled Nursing Administrator is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. |
| F842 Resident Records-Identifiable information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) | 3/13/2020 | **A. With respect to the specific resident/situation cited:**<br><br>Resident #72 experienced no negative outcomes as a result of the Polyethylene glycol powder that was administered by LPN #1.<br><br>The physician was contacted by LPN #1 and clarified the order and the physician issued no new orders. |
| | | **B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:**<br><br>On 2/5/20, DNS and RAC reviewed orders on the residents including residents admitted within the last 24 hours and checked to confirm accuracy in the EMARs.<br>No other issues were identified. |
| | | **C. With respect to what systemic measures have been put into place to address the stated concern:**<br><br>The RN Resident Assessment Coordinator and/or the DNS will conduct random unannounced medication pass observations weekly for 3 months to confirm administration in accordance with physician orders. |

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| | | The DNS or designee will report the results of the weekly audits, med pass observations at the Quality Assurance and Performance Improvement Meetings for 3 months.<br><br>During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period. |
| | | **D. With respect to how the plan of correction will be monitored:**<br><br>The Skilled Nursing Administrator is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. |
| F880 Infection Prevention and Control<br>CFR(s): 483.80(a)(1)(4)(e)(f) | 3/13/2020 | **A. With respect to the specific resident/situation cited:**<br><br>Resident #73 was observed and assessed for 72 hours following the dressing change; and experienced no negative outcomes as a result of gloves being changed frequently with no hand washing between changes. |
| | | **B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:**<br><br>On 2/5/20 refresher In-service was completed by the DNS for LPN #1 on appropriate treatment and wound care procedures, including appropriate hand washing during treatments and wound care. |
| | | **C. With respect to what systemic measures have been put into place to address the stated concern:**<br><br>Refresher training on the Infection control wellness program will be conducted with the |

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| | | nursing staff; including proper hand hygiene and glove usage during treatments. The refresher training is being conducted by the DNS and scheduled for 2/25/2020.<br><br>The RN Resident Assessment Coordinator and/or the DNS will conduct random unannounced treatment observations weekly for 3 months to confirm appropriate hand washing and glove usage.<br><br>The RAC and/or DNS will audit new orders including admissions orders for medication and dosage during clinical meetings, and will confirm the orders are entered correctly in PCC/EMARs, weekly for 3 months.<br><br>The DNS or designee will report the results of the weekly new order audits and treatment observations at the Quality Assurance and Performance Improvement Meetings for 3 months.<br><br>During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period. |
| | | **D. With respect to how the plan of correction will be monitored:**<br><br>The Skilled Nursing Administrator is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. |





*Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.*