STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495139	A. BUILDING _____ B. WING _____	10/24/2019

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LIFE CARE CENTER OF NEW MARKET	315 EAST LEE HIGHWAY NEW MARKET, VA 22844

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/22/19 through 10/24/19. 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 118 certified bed facility was 102 at the time of the survey. The survey sample consisted of 42 current resident reviews and 5 closed record reviews.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. 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 treat one out of 47 residents in the survey sample, Resident #12, with dignity and respect. The findings include: Resident #12 was admitted to the facility on 12/2/14. Diagnoses include but not limited to, high blood pressure, heart disease, edema, atrial	F 557	1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? -Resident #12 cognition care plan approaches will be reviewed with RN #1, and she received written education on dignity and documentation while surveyors were still on-site. 2. How will the facility identify other	11/29/19

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

Electronically Signed | 11/14/2019

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F 557	Continued From page 1 fibrillation, congestive heart failure, and diabetes. The annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/11/19 coded the resident as being severely impaired in ability to make daily life decisions, scoring a 3 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, toileting and hygiene; and was coded as independent for eating. A nurse's notes dated 10/12/19 at 3:46 AM that documented, "Resident came out of activities this evening and was sitting in her doorway moaning and pointing to her legs. she (sic) was told to stop her moaning if she was not going to be compliant with taking her medications and getting into bed to elevate her legs....Resident has refused to go to bed tonight. She has been sleeping in WC (wheel chair) with legs down." On 10/23/19 at 3:02 PM, an interview was conducted with RN (registered nurse) #1, who wrote the note. RN #1 stated, "Other residents complain about her moaning. She [Resident #12] wants you to fix her legs but doesn't want to take her meds (medications) for the edema or elevate them. She [Resident # 12] doesn't want to be compliant but she wants you to fix it. She [Resident #12] is alert and oriented [Resident has a BIMS of 3]. When asked if it is appropriate to tell a resident to stop your moaning if you are not going to be compliant, RN #1 stated, "I don't know, I guess not. It wasn't meant to be disrespectful. My main goal with her moaning was not to keep other residents awake." When asked is that how was how it was documented and reflected in the note, RN #1 stated, "It is not	F 557	residents having the potential to be affected by the same practice? -All residents within the facility have the potential to be affected by this practice. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? -By 11/25/2019, Staff Development Coordinator or Designee will re-educate on facility policy of Dignity and Respect. Any staff or volunteer that have not been in-serviced by 11/25/2019 will not be allowed to work until in-service is completed. All newly hired staff members will receive education on facility policy of Dignity and Respect during orientation. -Staff Development Coordinator or Designee will review Dignity and Respect Policy at All-Staff Meetings x3 months. 4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccurring? -Director of Nursing will present findings of audit to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. QAPI committee consists of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Manager, Pharmacy Consultant, and Medical Director.	

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relayed in any way in the note. It probably wasn't worded appropriately. It wasn't meant as disrespectful. This was probably written after about 3 hours of trying to get her into bed. I just ran out of ideas on how to persuade her to help herself."

On 10/23/19 at 4:16 PM, in an interview with RN #2, when asked how would it make her feel to be told to stop moaning if you are going to be non-compliant, RN #2 stated, "I would feel like my needs are not being met, my needs are being over looked. That is kind of like stop you're whining. I think that is a dignity thing."

The comprehensive care plan dated 7/30/19, documented, "The resident has impaired cognition" the interventions, dated 7/30/19, documented, "Allow for extra time for resident to respond to questions and instructions," "Ask yes or no questions in order to determine the resident's needs," "Cue, reorient and supervise as needed," "Face and speak clearly when communicating with resident...."

A review of the facility policy, "Dignity" documented, "Each resident has the right to be treated with dignity and respect. Interactions and activities with residents by staff, temporary agency staff, or volunteers must focus on maintaining and enhancing the resident's self-esteem, self-worth, and incorporating the resident's goals, preferences, and choices. Staff must respect the resident's individuality as well as, honor and value their input."

On 10/24/19 at 12:16 AM, ASM #1 (Administrative Staff Member) the Executive Director, and ASM #2, the Director of Nursing,

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F 557	Continued From page 3 were made aware of the findings. No further information was provided by the end of the survey.	F 557		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance	F 578		11/29/19

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F 578	Continued From page 4 with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review and clinical record review, it was determined that the facility staff failed to meet Advance Directive requirements for Thirteen of 47 residents in the survey sample, Residents #71, #52, #64, #27, #82, #88, #85, #49, #15, #8, #21, #50, #43. The facility staff failed to evidence resident advance directives or information for developing an advanced directive was periodically reviewed with the resident and/or Resident Representative (RR) to residents wished change anything or maintain the advanced directive as written and or formulate an advanced directive for Residents #71, #52, #64, #27, #82, #88, #85, #49, #15, #8, #21, #50, #43. The findings include: 1. The facility staff failed to evidence Resident #71's advance directives dated 12/27/09, was periodically reviewed with the resident and/or Resident Representative (RR) to determine if she wanted to change anything or maintain the advanced directive as written. Resident #71 was admitted to the facility on 1/8/18; diagnoses included but are not limited to, dementia, chronic obstructive pulmonary disease, high blood pressure, hypothyroidism, depression,	F 578	1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? -Resident #71 Advanced Directive reviewed with resident/responsible representative. -Resident #52 Social Services offered development of Advanced Directive -Resident #64 Advanced Directive reviewed with resident/responsible representative. -Resident #27 Advanced Directive reviewed with resident/responsible representative. -Resident #82 Social Services followed up on development of advanced directive with resident/responsible representative. -Resident #88 Social Services offered development of Advanced Directive -Resident #85 Social Services offered development of Advanced Directive -Resident #49 Social Services offered development of Advanced Directive -Resident #15 Social Services offered development of Advanced Directive -Resident #8 Social Services offered development of Advanced Directive -Resident #21 Social Services offered	

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F 578	Continued From page 5 bipolar disorder, and osteoarthritis. The annual MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 9/28/19 coded the resident as moderately significantly impaired in ability to make daily life decisions. A review of the clinical record revealed an advance directive dated 12/27/09. Further review failed to reveal any evidence of periodic review with Resident #71 to determine if she wanted to change anything or maintain the advanced directive as written. On 10/23/19 at 12:30 PM in an interview with OHM #3 (Other Staff Member), Director of Social Services, when asked if the facility does periodic reviews of advance directives with the residents and/or RP, OHM #3 stated, "I don't do that. I do not know if anyone does. We review the code status but I don't know about Advance Directives." On 10/24/19 at 7:57 AM, a follow up interview was conducted with OHM #3. She provided notes where code status was reviewed with Resident #71, but nothing evidencing advance directives had been reviewed. When asked if a periodic review or opportunity to establish advance directives later other than at admission was done, OSM #3 stated, "It is not being done." She stated that the only thing reviewed in care plan meetings is the code status. The comprehensive care plan dated 8/14/19, documented, "Resident has Advance Directive DNR - Do Not Resuscitate." This care plan included the interventions, "Code status will be reviewed on a quarterly basis and PRN (as needed)," and "Resident has signed Do Not	F 578	development of Advanced Directive -Resident #50 Social Services offered development of Advanced Directive -Resident #43 Advanced Directive reviewed with resident/responsible representative. 2. How will the facility identify other residents having the potential to be affected by the same practice? -All residents within the facility have the potential to be affected by this practice. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? -By 11/15/2019, Staff Development Coordinator or Designee will educate Social Services on facility policy for Advanced Directives. -By 11/25/2019, Social Services will audit all current residents medical records for advanced directives and review advanced directive with resident or resident representative. If resident does not currently have an advanced directive they will have the opportunity to obtain one or decline, and medical record will be updated in the progress notes by social services. -Social Services #1 will audit all admissions for Advanced Directives, offer support in obtaining advanced directive as resident/resident representative wishes, and documentation is present in the	

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F 578	Continued From page 6 Resuscitate (DNR)." The care plan did not include anything about the Advance Directives. A review of the facility policy, "Advance Directives" documented, "An Advance Directive is a written document prepared by the resident as to how he/she wants medical decisions to be made should he or she lose the ability to make decisions for him or herself. The two most commonly prepared advance directives are a living will and durable power of attorney for health care. However, (facility) also recognizes the following medical orders for advance directives: Do Not Resuscitate (DNR) order....Feeding Restrictions and Hydration Measures....Medication Restrictions....Do Not Hospitalize....Organ Donation....Autopsy Request....Other Treatment Restrictions.... 7. Each time the resident is admitted to the facility, quarterly, after a significant change, and as needed, Social Services should review the advance directive information for accuracy with the resident or legal representative and document the findings in the progress notes." On 10/24/19 at 12:16 AM, ASM #1 (Administrative Staff Member) the Executive Director, and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey. 2. The facility staff failed to evidence that a periodic review was conducted with Resident #52 and/or Resident Representative (RR) who did not have any Advance Directive, to determine if she wanted to develop an advanced directive at any time after the initial review and offer at the time of	F 578	medical record. Designee will complete audit weekly x90 days. -Social Services #2 will audit medical record for residents with quarterly and significant change care plan conferences to ensure advanced directive was reviewed and documentation is present in resident progress notes. Designee will complete audit weekly x60 days. 4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccurring? -Director of Nursing will present findings of audit to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. QAPI committee consists of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Manager, Pharmacy Consultant, and Medical Director.	

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admission.

Resident #52 was admitted to the facility on 6/2/17 with the diagnoses of but not limited to dementia, bipolar disorder, depression, insomnia, and osteoarthritis. The quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 9/11/19, coded the resident as being cognitively intact in ability to make daily life decisions.

A review of the clinical record failed to reveal any advance directive for Resident #52. The clinical record contained a "POST" (Virginia Physician Orders for Scope of Treatment) form dated 12/27/17, which contained some components of an Advance Directive (Section A: whether to attempt or not attempt CPR; Section B: whether to initiate comfort measures, limited interventions, or full interventions; and Section C: whether or not to provide artificially administered nutrition.)

On 10/23/19 at 12:30 PM in an interview with OSM #3 (Other Staff Member), Director of Social Services, when asked if the facility does periodic reviews of advance directives with the residents and/or RP, OSM #3 stated, "I don't do that. I don't know if anyone does. We review the code status but I don't know about advance directives."

On 10/24/19 at 7:57 AM, in a follow up interview with OSM #3, she provided notes where code status was reviewed with Resident #52 but not advance directives. When asked if a periodic review or opportunity to establish advance directives other than at admission was done, OSM #3 stated, "It is not being done." She stated that the only thing reviewed in care plan meetings is the code status.

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The comprehensive care plan dated 8/14/19, documented, "Resident has Advance Directive DNR - Do Not Resuscitate." This care plan included the interventions, "Code status will be reviewed on a quarterly basis and PRN (as needed)," and "Resident has signed Do Not Resuscitate (DNR)." The care plan did not include anything about a periodic review for advance directives.

On 10/24/19 at 12:16 AM, ASM #1 (Administrative Staff Member) the Executive Director, and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey.

3. The facility staff failed to evidence that the Advance Directives were periodically reviewed with Resident #64 and/or Resident Representative (RR) to determine if she wanted to change anything in her advance directive, dated 7/25/17, or maintain it as written.

Resident #64 was admitted to the facility on 6/8/18; diagnoses included but are not limited to, dementia, diabetes, high blood pressure, osteoarthritis, spondylosis, and carpal tunnel syndrome. The quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 9/19/19 coded the resident as being severely impaired in ability to make daily life decisions.

A review of the clinical record revealed advance directive dated 7/25/17. Further review failed to reveal any evidence of a periodic review to

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determine if Resident #64 and/or Resident Representative (RR) wanted to change anything in the advanced directive or maintain it as written.

On 10/23/19 at 12:30 PM in an interview with OSM #3 (Other Staff Member), Director of Social Services, when asked if the facility does periodic reviews of advance directives with the residents and/or RP, OSM #3 stated, "I don't do that. I don't know if anyone does. We review the code status but I don't know about Advance Directives."

On 10/24/19 at 7:57 AM, in a follow up interview with OSM #3, she provided notes where code status was reviewed but not Advance Directives. When asked if a periodic review or opportunity to establish Advance Directives later other than at admission was done, she stated, "It is not being done." She stated that the only thing reviewed in care plan meetings is the code status.

A comprehensive care plan revealed dated 7/2/19, documented, "Resident has Advance Directive CPR - Full Code." This care plan included the interventions, "Code status will be reviewed on a quarterly basis and PRN (as needed)," and "Resident has decided to remain a Full Code." The care plan did not include anything about the Advance Directives.

On 10/24/19 at 12:16 AM, ASM #1 (Administrative Staff Member) the Executive Director, and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey.

4. The facility staff failed to periodically review

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Resident #27's (or the resident's representative) decisions regarding advance directives.

Resident #27 was admitted to the facility on 07/02/2008 with a readmission on 04/15/2018. Resident #27's diagnoses included but were not limited to atrial fibrillation (1) and diabetes (2). Resident #27's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 08/07/19, coded Resident #27 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions.

Review of Resident #27's clinical record revealed a document "Advance Directives/Medical Treatment Decisions Acknowledgement of Receipt" dated 7/2/08 but failed to evidence documentation of periodic review after 7/2/08. Further review of the clinical record revealed a document "Consent for Treatment" dated 4/13/15, which documented the resident and/or resident's representative receiving information regarding advanced directives on readmission to the facility but failed to evidence documentation of periodic review after 4/13/15.

The comprehensive care plan for Resident #27 dated 08/15/2019 documented "Resident has Advance Directives DNR-Do Not Resuscitate; Date initiated: 08/14/2019; Revision on 08/14/2019." Under "Goal" it documented, "Resident's Advance Directives will be honored. Date initiated: 08/14/2019." Under "Interventions/Tasks" it documented, "Code status will be reviewed on a quarterly basis and PRN (as needed); Date initiated: 08/14/2019."

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On 10/22/19 at approximately 3:30 p.m., an interview was conducted with Resident #27. When asked if staff periodically review advance directives, Resident #27 stated, "I don't think so."

On 10/23/19 at 12:30 p.m., an interview was conducted with OSM (other staff member) #3, social services director. When asked if periodic reviews of Advance Directives are conducted with the residents and/or the resident's representative, OSM #3 stated, "I don't do that. I don't know if anyone does. We review the code status but I don't know about Advance Directives."

On 10/23/19 at approximately 1:00 p.m., a request was made in writing to ASM (administrative staff member) #2, the director of nursing, for additional information on any evidence of periodic advance directive review for Resident #27.

On 10/23/19 at approximately 5:30 p.m., a progress note was received from ASM #2 for Resident #27. The note documented, "Note Text: Significant Change of Condition: Resident was alert and oriented today. BIM (Brief Interview for Mental Status) score was 15/15. MOOD (depression rating scale) score was 03 indicated minimal depression ...Current code status is DNR (do not resuscitate). SS (social services) will continue to monitor for cognitive loss." The progress note failed to evidence documentation of periodic review of advance directives.

On 10/24/19 at approximately 8:00 a.m., an interview was conducted with OSM (other staff member) #3, the director of social services. When asked what is discussed during care plan meetings, OSM #3 stated that currently only code

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status is being reviewed in care plan meetings. OSM #3 stated that periodic review or offering to establish an advance directive is not being done at the quarterly care plan meetings or periodically at the facility.

The facility policy, "Advance Directives" documented, "7. Each time the resident is admitted to the facility, quarterly, after a significant change, and as needed, Social Services should review the advance directive information for accuracy with the resident or legal representative and document the findings in the progress notes."

On 10/24/19 at approximately 12:15 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:

1. Atrial fibrillation- A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html

2. Diabetes- 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.

5. The facility staff failed to periodically review Resident #82's (or the resident's representative)

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decisions regarding advance directives.

Resident #82 was admitted to the facility on 01/14/2019 with a readmission on 03/19/2019. Resident #82's diagnoses included but were not limited to major depressive disorder (1) and diabetes (2). Resident #82's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/18/2019, coded Resident #82 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions.

Review of Resident #82's clinical record revealed a document "Consent for Treatment" dated 3/19/19, which documented the resident and/or resident's representative receiving information regarding advanced directives on admission to the facility but failed to evidence documentation of periodic review after 3/19/19.

The comprehensive care plan for Resident #82 dated 08/15/2019 documented "Resident has Advance Directives DNR-Do Not Resuscitate; Date initiated: 08/15/2019; Revision on 08/15/2019." Under "Goal" it documented, "Resident's Advance Directives will be honored. Date initiated: 08/15/2019." Under "Interventions/Tasks" it documented, "Code status will be reviewed on a quarterly basis and PRN (as needed); Date initiated: 08/15/2019."

On 10/23/19 at approximately 9:15 p.m., an interview was conducted with Resident #82. When asked if staff periodically review advance directives, Resident #82 stated that he did not know what that was.

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On 10/23/19 at 12:30 p.m., an interview was conducted with OSM (other staff member) #3, social services director. When asked if periodic reviews of Advance Directives are conducted with the residents and/or the resident's representative, OSM #3 stated, "I don't do that. I don't know if anyone does. We review the code status but I don't know about Advance Directives."

On 10/23/19 at approximately 1:00 p.m., a request was made in writing to ASM (administrative staff member) #2, the director of nursing, for additional information on any evidence of periodic advance directive review for Resident #82.

On 10/23/19 at approximately 5:30 p.m., ASM #2 provided a packet of documents for Resident #82. The "Care Plan Conference Record" dated 5/13/2019 documented "Advance Directive: POST (Virginia Physician Orders for Scope of Treatment) Form." Review of the referenced document "POST" form for Resident #82 revealed a status of "DNR (do not resuscitate)/No CPR (cardiopulmonary resuscitation), Comfort Measures, No feeding tube" dated 01/15/19. Additional documents provided by the facility revealed a progress note for Resident #82. The note documented, "Note Text: Quarterly Note: BIM/PHQ9 (brief interview for mental status/patient health questionnaire) interview conducted with resident in the midafternoon in his room with minimal distractions. BIM score was 15 with no indication of cognitive loss...Resident current code status is DNR (do not resuscitate) ...SS (social services will continue to monitor."

On 10/24/19 at approximately 8:00 a.m., an interview was conducted with OSM (other staff

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member) #3, the director of social services. When asked what is discussed during care plan meetings, OSM #3 stated that currently only code status is being reviewed in care plan meetings. OSM #3 stated that periodic review or offering to establish an advance directive is not being done at the quarterly care plan meetings or periodically at the facility.

On 10/24/19 at approximately 12:15 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:

1. Major depressive disorder is a mood disorder. This information was obtained from the website: https://medlineplus.gov/ency/article/000945.htm.

2. Diabetes 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

6. The facility staff failed to evidence periodic reviews were conducted to provide Resident # 88 and/or Resident # 88's representative, with the opportunity to develop an advance directive.

Resident # 88 was admitted to the facility on 05/14/14 with diagnoses that included but were not limited to Parkinson's disease [1], osteoporosis [2] and anxiety [3].

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Resident # 88's most recent MDS (minimum data set), an quarterly assessment with an ARD (assessment reference date) of 10/08/19, coded Resident # 88 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being moderately impaired of cognition for making daily decisions.

The clinical record and the EHR (electronic health record) for Resident # 88 failed to evidence an advance directive.

On 10/23/19 at 12:30 PM in an interview was conducted with OSM [other staff member] # 3, Social Worker. When asked if the facility does periodic reviews of advance directives or to develop an advance directive with the residents and/or responsible party, OSM #3 stated, "I don't do periodic reviews. We review the code status."

On 10/24/19 at 7:57 AM, during a follow up interview with OSM #3; she provided notes where Resident #89's code status was reviewed but not advance directives. When asked if a periodic review or opportunity to establish advance directives, at a later- time other than at admission, was completed, OSM #3 stated, "It is not being done." She stated that the only thing reviewed in care plan meetings is the code status.

On 10/24/19 at 12:10 p.m. ASM [administrative staff member] # 1, executive director and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:

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[1] A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

[2] Makes your bones weak and more likely to break. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html.

[3] Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

7. The facility staff failed to evidence periodic reviews were conducted to provide Resident # 85 and/or Resident # 85's representative with the opportunity to develop an advance directive.

Resident # 85 was admitted to the facility on 06/29/13 and a readmission of 04/08/2019 with diagnoses that included but were not limited to chronic obstructive pulmonary disease [1], chronic kidney disease [2] and anxiety [3].

Resident # 85's most recent MDS (minimum data set), an quarterly assessment with an ARD (assessment reference date) of 10/02/19, coded Resident # 85 as scoring a nine on the brief interview for mental status (BIMS) of a score of 0 - 15, nine - being moderately impaired of cognition for making daily decisions.

The clinical record and the EHR (electronic health record) for Resident # 88 failed to evidence an advance directive.

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On 10/23/19 at 12:30 PM in an interview was conducted with OSM [other staff member] # 3, Social Worker. When asked if the facility does periodic reviews of advance directives, or to provide information and develop an advance directive with the residents and/or responsible party, OSM #3 stated, "I don't do periodic reviews. We review the code status."

On 10/24/19 at 7:57 AM, in a follow up interview with OSM #3, she provided notes where Resident #85's code status was reviewed but no information for review of the residents advance directives. When asked if a periodic review or opportunity for the resident's right to establish advance directives, at a later- time other than at admission, was done, OSM #3 stated, "It is not being done." She stated that the only thing reviewed in care plan meetings is the code status.

On 10/24/19 at 12:10 p.m. ASM [administrative staff member] # 1, executive director and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

[2] Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.htm

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l.

[3] Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.

8. The facility staff failed to evidence periodic reviews were conducted to provide Resident # 49 and/or Resident # 49's representative with the opportunity to develop an advance directive.

Resident # 49 was admitted to the facility on 04/09/2019 with diagnoses that included but were not limited to Parkinson's disease [1], high blood pressure and anxiety [2].

Resident # 49's most recent MDS (minimum data set), an quarterly assessment with an ARD (assessment reference date) of 09/06/19, coded Resident # 49 as scoring a four on the brief interview for mental status (BIMS) of a score of 0 - 15, four - being severely impaired of cognition for making daily decisions.

The clinical record and the EHR (electronic health record) for Resident # 49 failed to evidence an advance directive.

On 10/23/19 at 12:30 PM in an interview was conducted with OSM [other staff member] # 3, Social Worker. When asked if the facility does periodic reviews of advance directives or provides information to develop an advance directive with the residents and/or responsible party, OSM #3 stated, "I don't do periodic reviews. We review the code status."

On 10/24/19 at 7:57 AM, a follow up interview

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was conducted with OSM #3. She provided notes where code status was reviewed for Resident #49 but not advance directives. When asked if a periodic review or opportunity to establish advance directives at a later -time other than at admission was completed, OSM #3 stated, "It is not being done." She stated that the only thing reviewed in care plan meetings is the code status.

On 10/24/19 at 12:10 p.m. ASM [administrative staff member] # 1, executive director and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] [A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

[2] Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

9. The facility staff failed to evidence periodic reviews were conducted to provide Resident # 15 and/or Resident # 15's representative with the opportunity to develop an advance directive.

Resident # 15 was admitted to the facility on 03/10/17 and a readmission of 04/16/2019 with diagnoses that included but were not limited to hemiplegia [1], heart disease [2] and atrial fibrillation [3].

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Resident # 15's most recent MDS (minimum data set), an significant change assessment with an ARD (assessment reference date) of 04/16/19, coded Resident # 15 as scoring a seven on the brief interview for mental status (BIMS) of a score of 0 - 15, seven - being severely impaired of cognition for making daily decisions.

The clinical record and the EHR (electronic health record) for Resident # 15 failed to evidence an advance directive.

On 10/23/19 at 12:30 PM in an interview was conducted with OSM [other staff member] # 3, Social Worker. When asked if the facility does periodic reviews of advance directives or provides information to develop an advance directive with the residents and/or responsible party, OSM #3 stated, "I don't do periodic reviews. We review the code status."

On 10/24/19 at 7:57 AM, a follow up interview was conducted with OSM #3. She provided notes documenting the code status for Resident #15was reviewed, but no documentation evidencing advance directives were reviewed. When asked if a periodic review or opportunity to establish advance directives at a later -time other than at admission was completed, OSM #3 stated, "It is not being done." She stated that the only thing reviewed in care plan meetings is the code status.

On 10/24/19 at 12:10 p.m. ASM [administrative staff member] # 1, executive director and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

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References:
[1] Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

[2] There are many different forms of heart disease. The most common cause of heart disease is narrowing or blockage of the coronary arteries, the blood vessels that supply blood to the heart itself. This is called coronary artery disease and happens slowly over time. This information was obtained from the website: https://medlineplus.gov/heartdiseases.html.

[3] A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

10. The facility staff failed to evidence periodic reviews were conducted to provide Resident # 8 and/or Resident # 8's representative with the opportunity to develop an advance directive.

Resident # 8 was admitted to the facility on 03/10/17 and a readmission of 04/16/2019 with diagnoses that included but were not limited to hemiplegia [1], heart disease [2] and atrial fibrillation [3].

Resident # 8's most recent MDS (minimum data set), an significant change assessment with an ARD (assessment reference date) of 04/16/19, coded Resident # 8 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0

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F 578	Continued From page 23 - 15, 13 - being cognitively intact for making daily decisions. The clinical record and the EHR (electronic health record) for Resident # 8 failed to evidence an advance directive. On 10/23/19 at 12:30 PM in an interview was conducted with OSM [other staff member] # 3, Social Worker. When asked if the facility does periodic reviews of advance directives or to develop an advance directive with the residents and/or responsible party, she stated, "I don't do periodic reviews. We review the code status." On 10/24/19 at 7:57 AM, a follow up interview was conducted with OSM #3. She provided notes where code status for Resident #8 was reviewed but no documentation evidencing advance directives were reviewed. When asked if a periodic review or opportunity to establish advance directives at a later -time other than at admission was completed, OSM #3 stated, "It is not being done." She stated that the only thing reviewed in care plan meetings is the code status. On 10/24/19 at 12:10 p.m. ASM [administrative staff member] # 1, executive director and ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. References: [1] Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It can also occur in just one area, or it can be widespread This	F 578		

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information was obtained from the website: https://medlineplus.gov/paralysis.html.

[2] There are many different forms of heart disease. The most common cause of heart disease is narrowing or blockage of the coronary arteries, the blood vessels that supply blood to the heart itself. This is called coronary artery disease and happens slowly over time. This information was obtained from the website: https://medlineplus.gov/heartdiseases.html.

[3] A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

11. The facility staff failed to evidence periodic reviews were conducted to provide Resident # 21 and/or Resident # 21's representative with the opportunity to develop an advance directive.

Resident # 21 was admitted to the facility on 04/22/2019 with diagnoses that included but were not limited to dementia [1], high blood pressure and osteoarthritis [2].

Resident # 21's most recent MDS (minimum data set), an quarterly assessment with an ARD (assessment reference date) of 07/29/19, coded Resident # 21 as scoring a five on the brief interview for mental status (BIMS) of a score of 0 - 15, five - being severely impaired of cognition for making daily decisions.

The clinical record and the EHR (electronic health record) for Resident # 21 failed to evidence an advance directive.

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On 10/23/19 at 12:30 PM in an interview was conducted with OSM [other staff member] # 3, Social Worker. When asked if the facility does periodic reviews of advance directives or to develop an advance directive with the residents and/or responsible party, she stated, "I don't do periodic reviews. We review the code status."

On 10/24/19 at 7:57 AM, during a follow up interview with OSM #3, she provided notes where Resident #21's code status was reviewed but not the residents advance directives. When asked if a periodic review or opportunity to establish advance directives at a later -time, other than at admission, was done, OSM #3 stated, "It is not being done." She stated that the only thing reviewed in care plan meetings is the code status.

On 10/24/19 at 12:10 p.m. ASM [administrative staff member] # 1, executive director and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

[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:

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F 578	Continued From page 26	F 578		

https://medlineplus.gov/osteoarthritis.html.

12 The facility staff failed to evidence periodic reviews were conducted to provide Resident # 50 and/or Resident # 50's representative with the opportunity to develop an advance directive.

Resident # 50 was admitted to the facility on 05/18/13 and a readmission of 06/07/2019 with diagnoses that included but were not limited to dysphagia [1], high blood pressure [2] and atrial fibrillation [3].

Resident # 50's most recent MDS (minimum data set), an quarterly assessment with an ARD (assessment reference date) of 06/07/19, coded Resident # 50 as scoring a five on the brief interview for mental status (BIMS) of a score of 0 - 15, five - being severely impaired of cognition intact for making daily decisions.

The clinical record and the EHR (electronic health record) for Resident # 50 failed to evidence an advance directive.

On 10/23/19 at 12:30 PM in an interview was conducted with OSM [other staff member] # 3, Social Worker. When asked if the facility does periodic reviews of advance directives or to develop an advance directive with the residents and/or responsible party,OSM #3 stated, "I don't do periodic reviews. We review the code status."

On 10/24/19 at 7:57 AM, during a follow up interview with OSM #3, she provided notes where Resident #50's code status was reviewed but not the residents advance directives. When asked if a periodic review or opportunity to establish advance directives at a later -time, other than at

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admission, was done, OSM #3 stated, "It is not being done." She stated that the only thing reviewed in care plan meetings is the code status.

On 10/24/19 at 12:10 p.m. ASM [administrative staff member] # 1, executive director and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

[2] A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

13. The facility staff failed to evidence periodic reviews were conducted regarding Resident # 43's advance directive.

Resident # 43 was admitted to the facility on 06/05/18 and a readmission of 03/12/2019 with diagnoses that included but were not limited to dysphagia [1], high blood pressure [2] and atrial fibrillation [3].

Resident # 43's most recent MDS (minimum data set), an quarterly assessment with an ARD (assessment reference date) of 08/29/19, coded Resident # 43 as scoring a ten on the brief interview for mental status (BIMS) of a score of 0

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- 15, five - being severely impaired of cognition intact for making daily decisions.

The clinical record and the EHR (electronic health record) for Resident # 50 evidenced an "Advance Medical Directive" dated "21st November 2001." Further review failed to evidence periodic reviews of the advance directive.

On 10/23/19 at 12:30 PM in an interview was conducted with OSM [other staff member] # 3, Social Worker. When asked if the facility does periodic reviews of advance directives, OSM #3 stated, "I don't do periodic reviews. We review the code status."

On 10/24/19 at 7:57 AM, during a follow up interview with OSM #3, she provided notes where Resident #43's code status was reviewed but not the residents advance directives. When asked if a periodic review or opportunity to establish advance directives at a later -time, other than at admission, was done, OSM #3 stated, "It is not being done." She stated that the only thing reviewed in care plan meetings is the code status.

On 10/24/19 at 12:10 p.m. ASM [administrative staff member] # 1, executive director and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

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F 578	Continued From page 29 [2] A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		11/29/19

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F 584	Continued From page 30 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed maintain a comfortable and homelike environment for one of 47 residents in the survey sample, Resident # 85. The facility staff failed to maintain Resident # 85's over-the-bed-table was in good repair. The findings include: Resident # 85 was admitted to the facility on 06/29/13 and a readmission of 04/08/2019 with diagnoses that included but were not limited to chronic obstructive pulmonary disease [1], chronic kidney disease [2] and anxiety [3]. Resident # 85's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/02/19, coded Resident # 85 as scoring a nine on the brief interview for mental status (BIMS) of a score of 0 - 15, nine - being moderately impaired of cognition for making daily decisions. On 10/22/19 at approximately 12:45 p.m., and 2:45 p.m., Resident # 85's over-the-bed-table	F 584	1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? On 10/24/2019, resident #85 over-the-bed table was removed from the room and replaced while surveyors still on-site. 2. How will the facility identify other residents having the potential to be affected by the same practice? -All residents within the facility have the potential to be affected by this practice. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? -On 10/24/2019, 100% audit of all over-the-bed tables was completed. -Executive Director ordered sufficient supply of over-the-bed tables. -By 11/25/2019, Staff Development Coordinator will in-service all staff on	

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F 584	Continued From page 31 was observed. The edges were chipped and peeling, the trim surrounding the edges of the table was separated from the table exposes the bare wood fiber edges. On 10/23/19 at approximately 2:47 p.m., an interview was conducted with Resident # 85. When asked about the condition of his over-the-bed-table, Resident # 85 stated, "It needs to be fixed." On 10/24/19 at approximately 7:30 a.m., Resident # 85's over-the-bed-table was observed. The edges were chipped and peeling, the trim surrounding the edges of the table was separated from the table exposes the bare wood fiber edges. On 10/24/19 at approximately 7:30 a.m., Resident # 85's over-the-bed-table was observed with OSM [other staff member] # 1, director of maintenance. After observing the over-the-bed-table, OSM # 1 stated that it was in poor condition and in need of repair. OSAM # 1 was asked to measure the damaged edge of the table. Using a standardized carpenter's measuring tape, OSM # 1 stated that approximately twenty-five inches of the table edge was damaged. OSM #1 was asked to describe the process for identifying repairs in the facility's resident rooms. OSM # 1 stated, "We [maintenance department] inspect five rooms a week and but if a staff member sees something in need of a repair or fixing, they complete a work order and we check them and address them throughout the day" OSM # 1 stated that the condition of Resident # 1's over-the-bed-table should have been identified during rounds and replaced.	F 584	reporting any resident over-the-bed table that is need of repair or replacement in order to maintain a homelike environment. Staff will remove table and notify maintenance. Any staff member that has not completed in-service by 11/25/2019, will not be allowed to work until in-service is completed. All newly hired staff will receive education during orientation on creating and maintaining a homelike environment by removing any damaged over-the-bed tables when they notice them. -Maintenance Director or Designee will audit 5 resident over-the-bed tables per unit (25 total) 5 times per week x30 days, 3 times per week x30 days, and 1 time per week x30 days. 4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccurring? -Executive Director will present findings of audit to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. QAPI committee consists of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Manager, Pharmacy Consultant, and Medical Director.	

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F 584	Continued From page 32 On 10/24/19 at 12:10 p.m. ASM [administrative staff member] # 1, executive director and ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. References: [1] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. [2] Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html. [3] Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.	F 584		
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	F 607		11/29/19

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F 607	Continued From page 33 paragraph §483.95, 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 implement the abuse policy for immediately reporting an allegation of abuse to the state agency for one of 47 residents in the survey sample, Resident #33. The facility staff failed to report an allegation of abuse from Resident #33 to the state agency immediately and or within the required two hours after learning of the allegation. The findings include: A review of the facility policy, "Protection of Residents; Reducing the Threat of Abuse and Neglect," revealed, in part, the following: "Reporting and Response...All associates are mandated to immediately report suspected resident abuse and/or neglect to their immediate supervisor and/or facility representative. All alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin...will be immediately reported to the administrator and/or director of nursing...Facilities must 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." Resident #33 was admitted to the facility on 11/9/18 with diagnoses that include, but are not limited to recent right great toe removal, diabetes,	F 607	1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? -Facility Reported Incident for resident #33 was completed on 10/8/2019. 2. How will the facility identify other residents having the potential to be affected by the same practice? -All residents within the facility have the potential to be affected by this practice. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? -By 11/25/2019, Staff Development Coordinator will re-educate all staff on facility policy "Protection of Residents: Reducing the Threat of Abuse and Neglect", including reporting and response timeframes. Any staff member that has not completed re-education by 11/25/2019, will not be allowed to work until re-education is completed. All newly hired staff will receive education during orientation on facility policy "Protection of Residents: Reducing the Threat of Abuse and Neglect", including reporting and response timeframes in orientation. -Staff Development Coordinator or Designee will ask 5 different employees	

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F 607	Continued From page 34 and heart failure. He was discharged on 10/18/19. On the most recent MDS (minimum data set), an admission assessment with an assessment reference date of 817/19, Resident #33 was coded as being moderately impaired for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status). A review of a Facility Reported Incident (FRI) report related to Resident #33 revealed, in part, the following: "Report date: 10/8/18...Incident date: 10/4/18....[Resident #33] stated CNA (certified nursing assistant) was 'rough' with him during care and words she used was (sic) hurtful." The fax timestamp for this report to the state agency was 10/8/18. A review of Resident #33's clinical record revealed a progress note dated 10/6/18 at 11:20 a.m. This nurse's note documented, in part, the following: "Resident continues with SNF (skilled nursing facility care) following right great toe amputation and right foot diabetic ulcer. Alert and oriented...Resident tearful over treatment last night stating that CNA (certified nursing assistant) told him that 'just because he had a bigger bed now did not mean that he owned the room' when she moved his bed over. Also reported that she was rough in repositioning him and his neck is sore today. DON (director of nursing) and unit manager notified and witness form filled out by resident." [The nurse who wrote this note was unavailable for interview at the time of survey. The CNA named in the allegation was also not available for interview at the time of survey.] On 10/23/19 at 3:19 p.m., CNA (certified nursing assistant) # 3 was interviewed regarding reporting abuse allegations. She stated that all allegations	F 607	about reporting abuse and neglect 5 times per week x30 days, 3 times per week x30 days, and 1 time per week x30 days. 4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccurring? -Executive Director will present findings of audit to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. QAPI committee consists of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Manager, Pharmacy Consultant, and Medical Director.	

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F 607	Continued From page 35 of abuse should be immediately reported to the supervisor. On 10/24/19 at 9:05 a.m., LPN (licensed practical nurse) #1 was interviewed regarding reporting abuse allegations. She stated, "Any allegation should be reported as soon as possible to the DON (director of nursing) or whoever is on call for the facility for administration." On 10/24/19 at 11:05 a.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the DON (director of nursing), were interviewed. ASM #1 stated that the staff should report all allegations of abuse immediately, and that he or his designee should report them to the state agency within two hours of learning of the allegation. ASM #2 reviewed the FRI file regarding Resident #33 and stated, "I don't remember this at all. I don't know why it took so long for us to report this." 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	F 609		11/29/19

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F 609	Continued From page 36 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to report an allegation of abuse to the state agency in a timely manner for one of 47 residents in the survey sample, Resident #33. The facility staff failed to immediately report an allegation of abuse from Resident #33 to the state agency after learning of the allegation. The findings include: Resident #33 was admitted to the facility on 11/9/18 with diagnoses including, but not limited to recent right great toe removal, diabetes, and heart failure. He was discharged on 10/18/19. On the most recent MDS (minimum data set), an admission assessment with an assessment reference date of 817/19, Resident #33 was coded as being moderately impaired for making daily decisions, having scored nine out of 15 on	F 609	1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? -Facility Reported Incident for resident #33 was completed on 10/8/2019. 2. How will the facility identify other residents having the potential to be affected by the same practice? -All residents within the facility have the potential to be affected by this practice. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? -By 11/25/2019, Staff Development Coordinator will re-educate all staff on	

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LIFE CARE CENTER OF NEW MARKET	315 EAST LEE HIGHWAY NEW MARKET, VA 22844

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F 609	Continued From page 37 the BIMS (brief interview for mental status). A review of a Facility Reported Incident (FRI) report related to Resident #33 revealed, in part, the following: "Report date: 10/8/18...Incident date: 10/4/18....[Resident #33] stated CNA (certified nursing assistant) was 'rough' with him during care and words she used was (sic) hurtful." The fax timestamp for this report to the state agency was 10/8/18. A review of Resident #33's clinical record revealed a progress note dated 10/6/18 at 11:20 a.m. This nurse's note documented, in part, the following: "Resident continues with SNF (skilled nursing facility care) following right great toe amputation and right foot diabetic ulcer. Alert and oriented...Resident tearful over treatment last night stating that CNA (certified nursing assistant) told him that 'just because he had a bigger bed now did not mean that he owned the room' when she moved his bed over. Also reported that she was rough in repositioning him and his neck is sore today. DON (director of nursing) and unit manager notified and witness form filled out by resident." [The nurse who wrote this note was unavailable for interview at the time of survey. The CNA named in the allegation was also not available for interview at the time of survey.] On 10/23/19 at 3:19 p.m., CNA (certified nursing assistant) # 3 was interviewed regarding reporting abuse allegations. She stated that all allegations of abuse should be immediately reported to the supervisor. On 10/24/19 at 9:05 a.m., LPN (licensed practical nurse) #1 was interviewed regarding reporting abuse allegations. She stated, "Any allegation	F 609	facility policy "Protection of Residents: Reducing the Threat of Abuse and Neglect", including reporting and response timeframes. Any staff member that has not completed re-education by 11/25/2019, will not be allowed to work until re-education is completed. All newly hired staff will receive education during orientation on facility policy "Protection of Residents: Reducing the Threat of Abuse and Neglect", including reporting and response timeframes in orientation. -Staff Development Coordinator or Designee will ask 5 different employees about timeframes for reporting abuse and neglect allegations 5 times per week x30 days, 3 times per week x30 days, and 1 time per week x30 days. 4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccurring? -Executive Director will present findings of audit to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. QAPI committee consists of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Manager, Pharmacy Consultant, and Medical Director.	

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F 609	Continued From page 38 should be reported as soon as possible to the DON (director of nursing) or whoever is on call for the facility for administration." On 10/24/19 at 11:05 a.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the DON, were interviewed. ASM #1 stated that all allegations of abuse should be reported immediately by the staff, and that they should be reported to the state agency by him or his designee within two hours of learning of the allegation. ASM #2 reviewed the FRI file regarding Resident #33 and stated, "I don't remember this at all. I don't know why it took so long for us to report this." A review of the facility policy, "Protection of Residents; Reducing the Threat of Abuse and Neglect," revealed, in part, the following: "Reporting and Response...All associates are mandated to immediately report suspected resident abuse and/or neglect to their immediate supervisor and/or facility representative. All alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin...will be immediately reported to the administrator and/or director of nursing...Facilities must 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." No further information was provided prior to exit.	F 609		
F 622	Transfer and Discharge Requirements	F 622		11/29/19

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F 622 SS=D	Continued From page 39 CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to	F 622		

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discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information

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F 622	Continued From page 41 (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. 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 evidence the required information was provided to the receiving hospital on transfer for one of 47 residents in the survey sample, Residents #36. The facility staff failed to evidence what, if any, paperwork and information was provided to the receiving facility upon Resident #36's transfer to the hospital on 8/10/19. The findings include: Resident #36 was admitted to the facility on 1/16/18. Readmitted on 8/13/19, with the diagnoses of but not limited to atrial fibrillation, chronic kidney disease, anxiety disorder, spinal stenosis, and intervertebral disc degeneration of the lumbar region. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/20/19 coded the resident as being cognitively intact in ability to make daily life decisions. A review of the clinical record revealed a nurse's note dated 8/10/19 that documented, "Resident complained of increased lower back pain unresolved with prn (as needed) pain medication.	F 622	1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? -As of 10/24/2019, resident #36 had already safely returned to center from 8/10/2019 facility initiated transfer. 2. How will the facility identify other residents having the potential to be affected by the same practice? -All resident's that transfer out of the facility have the potential to be affected by this practice. -By 11/22/2019, Director of Nursing/Unit Manager will evaluate transfers/discharges to ensure documentation in the medical record reflects appropriate information was communicated to the receiving health care institution or provider for transfers and discharges since 11/1/2019. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur?	

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F 622	Continued From page 42 MD (medical doctor) made aware and new orders received to send resident to ED (emergency department) for eval (evaluation). Resident's daughter (name of daughter) notified of increased back pain and new MD orders. (Name of daughter) stated that she would meet her at (name of hospital). Resident transported via EMT (emergency medical technician) around 345-0400 (3:45 AM to 4:00 AM). Another nurse's note dated 8/10/19 documented, "Residents daughter called and stated that resident was admitted to the hospital for UTI (urinary tract infection)." Further review of the clinical record failed to evidence what, if any, paperwork and information was provided to the hospital upon Resident #36's transfer on 8/10/19. On 10/23/19 at 3:15 p.m., an interview was conducted with RN #2 (Registered Nurse). When asked to explain the process for transferring a resident to the hospital, RN #2 stated the nurses call the doctor, obtain an order to send the resident to the hospital and prepare the paperwork that is necessary to transfer a resident to the hospital. RN #2 was asked to describe the information that is provided to the hospital staff. RN #2 stated nurses are supposed to send an eInteract form, the care plan, and the bed hold policy. RN #2 stated nurses are supposed to write a note that documents all the information that is provided. On 10/24/19 at 9:10 AM, an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing. ASM #2 was asked to review the note and if what is written in the note evidenced sufficient information of what was provided to the hospital. ASM #2 stated, "No,	F 622	-By 11/25/2019, Staff Development Coordinator will re-educate licensed nurses on facility policy "Transfers and Discharges" and documentation required in the medical record. Any licensed nurse that has not completed re-education by 11/25/2019, will not be allowed to work until re-education is completed. All newly hired staff will receive education during orientation on facility policy "Transfers and Discharges" and documentation required in the medical record . -Director of Nursing or Designee will evaluate transfers/discharges to ensure documentation in the medical record reflects appropriate information was communicated to the receiving health care institution or provider 5 times per week x30 days, 3 times per week x30 days, and 1 time per week x30 days. 4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccurring? -Director of Nursing will present findings of audit to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. QAPI committee consists of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Manager, Pharmacy Consultant, and Medical Director.	

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F 622	Continued From page 43 it's missing the eInteract, which was not done. I'm not sure if they may have sent it in paper format and did not make a copy, but per the note, there is no documentation of what was sent." A review of the facility policy, "Transfers and Discharges" documented, "Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information. (C) Advance Directive Information. (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care." On 10/24/19 at 12:16 AM, ASM #1 (Administrative Staff Member) the Executive Director, and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a	F 623		11/29/19

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representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is

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transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide

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F 623	Continued From page 46 written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence that written notification of a hospital transfer was provided to the Resident Representative and/or Ombudsman, for three out of 47 residents in the survey sample, Residents #36, #31, and #99. The facility staff failed to evidence that written notification of a hospital transfer was provided to Resident #36 and/or Resident Representative and the Ombudsman, for a hospital transfer on 8/10/19. The facility staff failed to evidence written notification of discharge was provided to the ombudsman and the resident or resident's representative for a facility-initiated transfer to the hospital of Resident #31on 10/11/2019 and Resident #99 on 8/7/19. The findings include: 1. Resident #36 was admitted to the facility on 1/16/18. Readmitted on 8/13/19, with the diagnoses of but not limited to atrial fibrillation, chronic kidney disease, anxiety disorder, spinal stenosis, and intervertebral disc degeneration of the lumbar region. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/20/19 coded the resident as being cognitively intact in ability to make daily life	F 623	1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? -On 11/12/2019, business office staff sent notification of Transfer/Discharge to long term care ombudsman for the following residents: *#31 transferred to hospital on 10/11/2019, and returned to facility. *#36 transferred to hospital on 8/10/2019, and returned to facility. *#99 planned discharge and Transfer/discharge was sent on 11/15/19. 2. How will the facility identify other residents having the potential to be affected by the same practice? -All resident's that transfer/discharge from the facility have the potential to be affected by this practice. -By 11/22/2019, Director of Nursing and Business Office Designee will audit residents that transferred/discharged from facility since 11/1/2019 to ensure written transfer/discharge notification has been given to resident/resident representative,	

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F 623	Continued From page 47 decisions. A review of the clinical record revealed a nurse's note dated 8/10/19 that documented, "Resident complained of increased lower back pain unresolved with prn (as needed) pain medication. MD (medical doctor) made aware and new orders received to send resident to ED (emergency department) for eval (evaluation). Resident's daughter (name of daughter) notified of increased back pain and new MD orders. (Name of daughter) stated that she would meet her at (name of hospital). Resident transported via EMT (emergency medical technician) around 345-0400 (3:45 AM to 4:00 AM). Another nurse's note dated 8/10/19 documented, "Residents daughter called and stated that resident was admitted to the hospital for UTI (urinary tract infection)." Further review of the clinical record failed to evidence that written notification of the hospital transfer was provided to the Resident #36 and/or Resident Representative and the Ombudsman. On 10/24/19 at 8:13 AM, in an interview with ASM #2 (Administrative Staff Member) the Director of Nursing, she stated that before switching computer systems, the front desk was sending out the notifications. ASM #3 stated that when the facility switched to the new computer system, it was dropped because front desk was provided with a paper of who was discharged before and when the system was changed, the form that was provided to the front desk was no longer being done and so the notifications were not done. On 10/24/19 at 8:35 AM, in an interview with	F 623	and long term care ombudsman. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? -By 11/22/2019, Staff Development Coordinator will educate designated business office staff on process of checking Point Click Care for transfers/discharges and sending written transfer/discharge notification to long term care ombudsman and resident/resident representative. -Business Office Manager or Designee will evaluate all transfers/discharges from facility to ensure written transfer/discharge notification was sent to resident/resident representative and long term care ombudsman 5 times per week x30 days, 3 times per week x30 days, and 1 time per week x30 days. 4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccurring? -Director of Nursing will present findings of audit to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. QAPI committee consists of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Manager, Pharmacy Consultant, and Medical Director.	

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OSM #4 (Other Staff Member), the front desk staff, she stated that the new system went into effect 7/1/19. OSM #4 stated, "We send documentation to the family and the Ombudsman. We generate a letter and we mail that and copy the envelope, the notice of transfer and discharge, notice of non-coverage form. All of this is generated and copied and sent to the Ombudsman and the family and is kept all together. If they go to the hospital and come back, I send the letter and bed hold to the family." When asked about the 8/10/19 hospital transfer for Resident #36, OSM #4 stated, "I have no evidence of Ombudsman or written family notification."

A review of the facility policy, "Transfers and Discharges" documented, "Emergency Transfers: When as resident is temporarily transferred on an emergency basis to an acute care facility, notice of the transfer may be provided to the resident and resident representative as soon as practicable, according to 42 CFR 483.15(c)(4)(ii)(D). Copies of notices for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as a list of residents on a monthly basis. Residents who are sent emergently to the hospital are considered facility-initiated transfers because the resident's return is generally expected."

On 10/24/19 at 12:16 AM, ASM #1 (Administrative Staff Member) the Executive Director, and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey.

2. The facility staff failed to evidence written notification of discharge was provided to the

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ombudsman and the resident or resident's representative for a facility-initiated transfer of Resident #31 on 10/11/2019.

Resident #31was admitted to the facility on 08/09/2019. Readmission on 10/15/2019 with diagnoses that included but were not limited to chronic respiratory failure (1) and traumatic brain injury (2). Resident #31's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 08/09/19, coded Resident #31 in a persistent vegetative state/no discernible consciousness.

The nurse's "Progress Notes," dated "10/11/2019 12:26 (12:26 p.m.)" for Resident #31 documented, "Respiratory therapist in to do trach (tracheostomy) (3) change. Upon trying to suction resident prior to trach change RT (respiratory therapist) was unable to advance catheter in to inner cannula to suction resident d/t (due to) resistance. Trach was not changed. Inner cannula changed. RT spoke with NP (nurse practitioner) and order received to send resident to ER (emergency room) for eval (evaluation) and tx (treatment) r/t (related to) fever and trach malfunction. Resident continues with orange/red color drainage with inner cannula changes noted with foul odor. VSS (vital signs stable). O2 (oxygen) sat (saturation) 98% (percent). Report called to [Name of Hospital] and 911 called to transport resident."

The nurse's "Progress Notes," dated "10/11/2019 17:11 (5:11 p.m.)" for Resident #31 documented, "Called [Name of Hospital] for update. Per [Name of Staff member] resident is going to be admitted overnight for possible procedure in the morning for trach change."

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The nurse's "Progress Notes," dated "10/16/2019 03:41 (3:41 a.m.)" for Resident #31 documented, "Adjusting well to readmission into facility without any noted problems ..."

Review of Resident #31's clinical record failed to evidence that written notification of discharge was provided to the resident or representative and the ombudsman for the facility initiated transfer on 10/11/19.

On 10/23/19 at 3:15 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 was asked to explain the facility process for transferring a resident to the hospital. RN #2 stated the nurses call the doctor, obtain an order to send the resident to the hospital and prepare the paperwork that is necessary to transfer a resident to the hospital. RN #2 was asked to describe the information that is provided to the hospital staff. RN #2 stated nurses are supposed to send an e-interact form, the care plan, and the bed hold policy. RN #2 stated nurses are supposed to write a note that documents all the information that is provided.

On 10/23/19 at approximately 4:00 p.m., a request was made via a list provided to ASM (administrative staff member) #2, the director of nursing for evidence that written notification of discharge was provided to Resident #31 or representative and the ombudsman for the facility initiated transfer on 10/11/2019.

On 10/24/19 at 8:35 a.m., an interview was conducted with OSM (Other Staff Member) #4, the front desk, staff member. When asked for the evidence of written notification regarding the

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facility-initiated transfer of Resident #31 on 10/11/19, OSM #4 stated that she did not have any evidence for that date. OSM #4 stated the only transfer information she had for Resident #31 was prior to July 2019.

On 10/24/19 at approximately 12:15 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the above concern.

No further information was presented prior to exit.

References:

1. Respiratory failure is a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide. Sometimes you can have both problems. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=respiratory+failure&_ga=2.10765815.252353412.1572267082-1838772440.1562936034

2. Traumatic brain injury- Happens when a bump, blow, jolt, or other head injury causes damage to the brain. Symptoms of a TBI may not appear until days or weeks following the injury. A concussion is the mildest type. It can cause a headache or neck pain, nausea, ringing in the ears, dizziness, and tiredness. People with a moderate or severe TBI may have those, plus other symptoms: A headache that gets worse or does not go away, repeated vomiting or nausea, Convulsions or seizures, Inability to awaken from sleep, Slurred speech, Weakness or numbness in the arms and legs, dilated eye pupils. This

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information was obtained from the website: https://medlineplus.gov/traumaticbraininjury.html

3. Tracheostomy- A surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube.. This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm.

3. Resident #99 was transferred to the hospital on 8/7/19. The facility staff failed to evidence that written notification regarding the transfer was provided to the resident, resident representative and/or the ombudsman.

Resident #99 was admitted to the facility on 7/29/19. Resident #99's diagnoses included but were not limited to heart attack, high blood pressure and shortness of breath. Resident #99's most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 8/5/19, coded the resident's cognition as moderately impaired.

Review of Resident #99's clinical record revealed the resident was transferred to the hospital on 8/7/19 due to an episode of vomiting bright blood and pressure to the chest. Further review of Resident #99's clinical record failed to reveal documentation to evidence the resident, resident representative and/or the ombudsman was provided written notification regarding the transfer.

On 10/24/19 at 8:35 a.m., in an interview with OSM (Other Staff Member) #4, the front desk

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F 623	Continued From page 53 staff. OSM #4 stated she could not provide written notice of transfer when Resident #99 was transferred to the hospital on 8/7/19. On 10/24/19 at 12:24 p.m., ASM #1 (the executive director) and ASM #2 were made aware of the above concern. No further information was provided prior to exit.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which	F 625		11/29/19

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F 625	Continued From page 54 specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined facility staff failed to evidence that written bed hold notice was provided to the resident or resident's representative for a facility-initiated transfer for two of 47 residents in the survey sample, Resident #31 and Resident #99. The facility staff failed to evidence that written bed hold notice was provided to Resident #31 or the resident's representative for a facility-initiated transfer of the resident on 10/11/2019 and to Resident #99 or the resident's representative when the resident was discharged to the hospital on 8/7/19. The findings include: 1. Resident #31 was admitted to the facility on 08/09/2019. Readmitted on 10/15/2019 with diagnoses that included but were not limited to chronic respiratory failure (1) and traumatic brain injury (2). Resident #31's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 08/09/19, coded Resident #31 in a persistent vegetative state/no discernible consciousness. The nurse's "Progress Notes," dated "10/11/2019 12:26 (12:26 p.m.)" for Resident #31 documented, "Respiratory therapist in to do trach (tracheostomy) (3) change. Upon trying to suction resident prior to trach change RT (respiratory therapist) was unable to advance catheter in to inner cannula to suction resident d/t	F 625	1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? -Resident #31 and #99 safely returned to center following facility initiated transfer. 2. How will the facility identify other residents having the potential to be affected by the same practice? -All residents transferred to the hospital have the potential to be affected by this practice. -On 11/8/2019, Director of Nursing reviewed documentation on residents currently at the hospital and verified bed hold policy was given to resident/resident representative upon transfer to hospital. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? -By 11/25/2019, Staff Development Coordinator will re-educate licensed nurses on facility policy "Bed hold/Reservation of Room" and documentation required in the medical record. Any licensed nurse that has not completed re-education by 11/25/2019, will not be allowed to work until re-education is completed. All newly hired	

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F 625	Continued From page 55 (due to) resistance. Trach was not changed. Inner cannula changed. RT spoke with NP (nurse practitioner) and order received to send resident to ER (emergency room) for eval (evaluation) and tx (treatment) r/t (related to) fever and trach malfunction. Resident continues with orange/red color drainage with inner cannula changes noted with foul odor. VSS (vital signs stable). O2 (oxygen) sat (saturation) 98% (percent). Report called to [Name of Hospital] and 911 called to transport resident." The nurse's "Progress Notes," dated "10/11/2019 17:11 (5:11 p.m.)" for Resident #31 documented, "Called [Name of Hospital] for update. Per [Name of Staff member] resident is going to be admitted overnight for possible procedure in the morning for trach change." Review of Resident #31's clinical record failed to evidence that written bed hold notification was provided to the resident or representative for the facility initiated transfer on 10/11/19. On 10/23/19 at approximately 4:00 p.m., a request was made via a list provided to ASM (administrative staff member) #2, the director of nursing for evidence that written bed hold notice was provided to Resident #31 or the resident representative for the facility initiated transfer on 10/11/2019. On 10/24/19 at approximately 8:00 a.m., ASM #2 provided a document "SBAR (situation, background, assessment, recommendations) Communication Form and Progress Note for RNs/LPN/LVNs [registered nurse, licensed practical nurse, licensed vocational nurse]" dated "10/11/2019 11:30 a.m." The document failed to	F 625	staff will receive education during orientation on facility policy "Bed hold/Reservation of Room" and documentation required in the medical record . -Director of Nursing or Designee will evaluate facility initiated transfers to the hospital to ensure written bed hold policy was given per policy validated by documentation in the medical record 5 times per week x30 days, 3 times per week x30 days, and 1 time per week x30 days. 4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccurring? -Director of Nursing will present findings of audit to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. QAPI committee consists of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Manager, Pharmacy Consultant, and Medical Director.	

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evidence written documentation that a bed hold notice was provided to the resident or representative for the facility initiated transfer on 10/11/19 for Resident #31. The document "Nursing Home to Hospital Transfer Form" dated "10/11/2019 12:03 PM" also failed to evidence written documentation that the bed hold notice was provided to Resident #31or the resident or representative for the facility initiated transfer on 10/11/19.

On 10/23/19 at 3:15 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 was asked to explain the facility process for transferring a resident to the hospital. RN #2 stated the nurses call the doctor, obtain an order to send the resident to the hospital and prepare the paperwork that is necessary to transfer a resident to the hospital. RN #2 was asked to describe the information that is provided to the hospital staff. RN #2 stated nurses are supposed to send an e-interact form, the care plan, and the bed hold policy. RN #2 stated nurses are supposed to write a note that documents all the information that is provided.

On 10/24/19 at 8:35 a.m., an interview was conducted with OSM (Other Staff Member) #4, the front desk, staff member. When asked if written bed hold notice is provided to residents or resident representative, OSM #4 stated that it is but the new computer system started 7/1/19. OSM #4 stated, "We mail a notification of discharge and the bed hold notice to the resident or represent, copy the envelope and keep it in a book." OSM #4 stated, "Up until July it was all on paper so we kept it on paper." OSM #4 provided a binder containing the above referenced notices, copies of the discharge letters and copied

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envelopes for discharged residents. When asked for the evidence of written bed hold notice for the facility-initiated transfer of Resident #31 to the hospital on 10/11/19, OSM #4 stated that she did not have any evidence for that transfer. OSM #4 stated the only transfer information she had for Resident #31 was prior to July 2019.

A review of the facility policy, "Bedhold [Sic.]/Reservation of Room" documented, "The Bed-hold policy should be given upon admission, upon transfer of a resident to the hospital (if in an emergency within 24 hours), or the resident goes on therapeutic leave of absence. The facility will provide written information to the resident or resident representative the nursing facility policy on bed-hold periods and the residents return to the facility to ensure that residents are made aware of the facility's bed-hold and reserve bed payment policy before and upon transfer to a hospital ..."

On 10/24/19 at approximately 12:15 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the above concern.

No further information was presented prior to exit.

References:

1. Respiratory failure is a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide. Sometimes you can have both problems. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=respiratory+failure&_

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ga=2.10765815.252353412.1572267082-1838772440.1562936034

2. Traumatic brain injury- Happens when a bump, blow, jolt, or other head injury causes damage to the brain. This information was obtained from the website: https://medlineplus.gov/traumaticbraininjury.html

3. Tracheostomy- A surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube. This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm.

2. The facility staff failed to provide Resident #99 or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 8/7/19.

Resident #99 was admitted to the facility on 7/29/19. Resident #99's diagnoses included but were not limited to heart attack, high blood pressure and shortness of breath. Resident #99's most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 8/5/19, coded the resident's cognition as moderately impaired.

Review of Resident #99's clinical record revealed the resident was transferred to the hospital on 8/7/19 due to an episode of vomiting bright blood and pressure to the chest. Further review of Resident #99's clinical record failed to reveal documentation to evidence the facility, bed hold policy was provided to the resident and/or the

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LIFE CARE CENTER OF NEW MARKET	315 EAST LEE HIGHWAY NEW MARKET, VA 22844

(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 625	Continued From page 59 representative for the facility initiated transfer to the hospital on 8/7/19. On 10/23/19 at 3:15 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 was asked to explain the facility process for transferring a resident to the hospital. RN #2 stated the nurses call the doctor, obtain an order to send the resident to the hospital and prepare the paperwork that is necessary to transfer a resident to the hospital. RN #2 confirmed a bed hold policy is supposed to be sent with residents when they are transferred to the hospital. RN #2 stated nurses are supposed to write a note that documents all the information that is provided. On 10/24/19 at 8:35 a.m., in an interview with OSM (Other Staff Member) #4, the front desk staff, she stated that the new system went into effect 7/1/19. OSM #4 stated, "We send documentation to the family and the Ombudsman. We generate a letter and we mail that and copy the envelope, the notice of transfer and discharge, notice of non-coverage form. All of this is generated and copied and sent to the Ombudsman and the family and is kept all together. If they go to the hospital and come back, I send the letter and bed hold to the family." On 10/24/19 at 12:24 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was provided prior to exit.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		11/29/19

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F 656	Continued From page 60 §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). (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	F 656		

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F 656	Continued From page 61 requirements set forth in paragraph (c) of this section. 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 develop and implement the comprehensive plan of care for three of 47 residents in the survey sample, Residents #44, #20, and #50. The findings include: 1. The facility staff failed to implement Resident #44's comprehensive care plan to look at and loosen a physical restraint per physician orders every 30 minutes. Resident #44 was admitted to the facility on 8/8/18. Readmitted on 5/2/19 with diagnoses including, but not limited to history of a stroke, obstructive uropathy (1) and dementia with behaviors (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 9/3/19, Resident #44 was coded as being severely cognitively impaired for making daily decisions, having scored five out of 15 on the BIMS (brief interview for mental status). He was coded as having an indwelling catheter in his bladder, and as having a physical restraint on a daily basis. A review of Resident #44's comprehensive care plan dated 8/28/19 revealed, in part, the following: "The resident uses abdominal binder for suprapubic cath (catheter). The resident will remain free of complications related to restraint use, including contractures, skin breakdown,	F 656	1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? -Resident #44, on 10/24/2019, staff working with resident were demonstrated how to loosen and check abdominal binder with reminder of frequency of checks as indicated on the care plan. On 11/11/2019, kardex was reviewed to ensure loosening protocol and duration timeframes. -Resident #20, on 10/24/2019, staff working with resident were reminded of fluid intake documentation as indicated on care plan. -Resident #50, on 10/23/2019, a new off-loading pillow was placed and staff working with resident were demonstrated on application of off-loading heels and ensuring heels were not resting on mattress despite intervention in place. On 10/24/2019, kardex was reviewed to ensure guidelines for off-loading. 2. How will the facility identify other residents having the potential to be affected by the same practice? -All residents have the potential to be affected by deficient practice if any part of the patient centered comprehensive care	

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F 656	Continued From page 62 altered mental status, isolation, or withdrawal through review date...Alternatives to abdominal binder was ABD (abdominal) pad and tape, but resident started pulling at suprapubic catheter; therefore abdominal binder was reinstated...RESTRAINT USE: Apply abdominal binder, check every 30 minutes and release every 2 hours." A review of Resident #44's clinical record revealed the following physician's order dated 8/21/19: "Abdominal binder: Check abdominal binder every 30 minutes and release every 2 hours every shift for safety, to keep resident from pulling at suprapubic catheter (3)." On 10/23/19 two surveyors continuously observed Resident #44, from 1:51 p.m. until 4:01 p.m. (135-minute period). During this time, Resident #44 was positioned in a reclining chair across from a nurses' station, just outside the main dining room. Resident #44's legs, torso, and arms were covered with a blanket. At no time during this observation did any staff member look underneath the blanket to verify the position of or to loosen Resident #44's abdominal binder, worn under his shirt. On 10/24/19 at 9:03 a.m., LPN (licensed practical nurse) #1 was interviewed. When asked if she had taken care of Resident #44 on 10/23/19, LPN #1 stated, "Yes I did." When asked what restraint Resident #44 used, LPN #1 stated, "He has an abdominal binder. He has a suprapubic catheter. Without the binder, he will rip [the catheter] out. He has pulled it out before and had to go back to have it replaced. That's why he has the binder." When asked why the abdominal binder is considered a restraint, LPN #1 stated, "He can't	F 656	plan is not implemented. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? -By 11/25/2019, Staff Development Coordinator will re-educate licensed nurses on implementation of comprehensive care plan and utilizing kardex for Certified Nursing Assistants. Any licensed nurse or certified nursing assistant that has not completed re-education by 11/25/2019, will not be allowed to work until re-education is completed. All newly hired staff will receive education during orientation on facility policy "Care Planning and Interventions" and utilizing the kardex . -Director of Nursing or Designee will observe 10 residents weekly x12 weeks to validate patient centered comprehensive care plan is implemented as written. Three of the observations will include a restraint if applicable, fluid restriction, and off-loading heels pillow; while the other 7 will be random. 4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccurring? -Director of Nursing will present findings of audit to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. QAPI committee consists of Executive	

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F 656	Continued From page 63 take it off by himself, and he can't really access his abdominal area like normal because it is there." When asked what orders accompany the use of the abdominal binder, LPN #1 stated, "We are supposed to check it every 30 minutes." When asked what "checking" the binder means, LPN #1 stated, "We are supposed to actually look at it. That's all, I think." When asked if she was aware of anything that needed to be done every two hours, LPN #1 stated, "No. I'm not familiar with anything else." LPN #1 was asked to check the physicians' orders for Resident #44. After reviewing the orders, LPN #1 stated, "We are supposed to loosen it every two hours." When asked if she had looked at Resident #44's abdominal binder every thirty minutes on 10/23/19, LPN #1 stated, "No, I didn't." When asked if she loosened the resident's abdominal binder every two hours on 10/23/19, LPN #1 stated, "No, I didn't do that either. I'm sorry." When asked if looking at and loosening Resident #44's binder were a part of Resident #44's comprehensive care plan, LPN #1 stated, "Yes, I'm sure it is." When asked the importance of a resident's care plan, LPN #1 stated, "So we know what to do for them. When I first start working with a resident, I looked at the care plan often. I ask those questions in report. I want to know what I'm doing, but I've been taking care of [Resident #44] a long time. I haven't looked at the care plan very much lately, I'll admit." On 10/24/19 at 11:00 a.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. A review of the facility policy, "Care Planning and Interventions," revealed, in part, the following:	F 656	Director, Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Manager, Pharmacy Consultant, and Medical Director.	

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F 656	Continued From page 64 "The interdisciplinary team meets on a scheduled basis and develops an individualized care plan. Interdisciplinary means that professional disciplines, as appropriate, work together to provide the greatest benefit to the resident...The Care Plan addresses, to the extent possible...Resident-specific interventions." No further information was provided prior to exit. (1) "Obstructive uropathy is a condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys." This information is taken from the website https://medlineplus.gov/ency/article/000507.htm. (2) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm. (3) "A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly. You may need a catheter because you have urinary incontinence (leakage), urinary retention (not being able to urinate), surgery that made a catheter necessary, or another health problem." This information is taken from the website https://medlineplus.gov/ency/patientinstructions/000145.htm. 2. The facility staff failed to implement Resident #20's comprehensive care plan to monitor the resident's fluid intake on multiple shifts during September 2019 and October 2019.	F 656		

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Resident #20 was admitted to the facility on 4/19/18, and most recently readmitted on 9/5/19 with diagnoses including, but not limited to ESRD (end stage renal disease) (1) and COPD (chronic obstructive pulmonary disease) (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 7/26/19, Resident #20 was coded as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as having received dialysis during the look back period.

A review of Resident #20's comprehensive care plan dated 9/16/19 revealed, in part, the following: "Dialysis r/t related to) renal (kidney) failure...Fluid restriction as ordered."

A review of Resident #20's clinical record revealed the following physician's order, dated 9/5/19: "Fluid Restriction 1500 ml/day (milliliters per day). From Kitchen: Breakfast 720 ml, Lunch 240 ml, dinner 240 ml. From Nursing Days 150 ml, eves (evenings) 150 ml) nights 0 ml. Every shift document amount consumed."

A review of Resident #20's September 2019 and October 2019 MARs (medication administration records revealed blanks on the following days in the space where the fluid restriction enforcement should have been documented: 9/7/19 day shift, 9/8/19 day shift, 9/9/19 day shift, 9/12/19 day and evening shifts, 9/19/19 evening shift, 9/21/19 day and evening shifts, 9/24/19 evening shift, 9/30/19 evening shift, 10/1/10 evening shift, 10/8/19 evening shift, 10/15/19 evening shift, and 10/18/19 day shift.

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On 10/24/19 at 9:01 a.m., LPN (licensed practical nurse) #1 was interviewed. LPN #1 stated she is not familiar with Resident #20's care. When shown the above-referenced MARs containing the blanks for the fluid restriction documentation, and when asked what these blanks mean, LPN #1 stated, "I don't want to say what I think it means. Because I think, it's not good. I need to find out."

On 10/24/19 at 10:07 a.m., LPN #5 was interviewed. LPN #5 stated she was very familiar with Resident #20's care. When asked why Resident #20 was on a fluid restriction, LPN #5 stated, "He is a dialysis patient. Typically, they have some kind of fluid restriction." When asked what she knew about Resident #20's restrictions, LPN #5 stated, "His fluid intake is monitored every shift. We keep track of what the resident takes in. Sometimes the aides record it sometimes I record it. But at the end of the shift, there is a box for me to add up all the totals and sign off on the total." When LPN #5 was shown the MARs referenced above for Resident #20, and when asked about blank spots, LPN #5 stated, "If a box is not signed off and totaled, I can't tell how much he got. There is no way to tell. There is no way to know how much he would be allowed to have for the rest of the day. I can't see how anybody would miss that." When asked what the lack of documentation means, LPN #5 stated, "Well, if it's not documented, I can only imagine it wasn't done. It doesn't look like anybody kept up with his fluid on those shifts." When asked the purpose of a resident's comprehensive care plan, LPN #5 stated, "The care plan should always be followed. It is their plan of care. It is like a guideline to follow."

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On 10/24/19 at 11:00 a.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

(1) "End-stage kidney disease (ESKD) is the last stage of long-term (chronic) kidney disease. This is when your kidneys can no longer support your body's needs. End-stage kidney disease is also called end-stage renal disease (ESRD)." This information is taken from the website https://medlineplus.gov/ency/article/000500.htm.

(2) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
3. The facility staff failed to implement Resident # 50 comprehensive care plan to maintain Resident # 50's heels elevated when in bed.

Resident # 50 was admitted to the facility on 05/18/2013 with a readmission on 06/07/2018 with diagnoses that included but were not limited to: pain, hemiplegia [1] and aphasia [2]. Resident # 50's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/26/19, coded Resident # 50 as scoring a five on the brief interview for mental status (BIMS) of a score of 0 - 15, five - being severely impaired of cognition for making daily decisions. Section M "Skin Conditions" coded Resident # 50 as being at risk for developing pressure ulcers.

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The comprehensive care plan for Resident # 50's skin integrity dated 06/24/2019 documented, "The resident has potential for impaired skin integrity r/t [related to] fragile skin. Revision Date: 10/23/2019." Under "Interventions" it documented, "Encourage heels while up in bed. Date Initiated: 06/24/2019."

On 10/22/19 at 12:25 p.m. an observation of Resident # 50 was conducted with CNA [certified nursing assistant] # 3. Resident # 50 was observed lying in bed with his legs covered by a blanket. Resident #50 was asked if this surveyor could look at his feet with the assistance of CNA # 3. Resident # 50 stated, "Yes." CNA # 3 removed the blanket exposing Resident # 50's feet and lower legs [below the knees]. Observation of Resident # 50's lower legs revealed a cushion and pillow under both calves. Observation of Resident # 50 right and left heels revealed they were resting directly on the bed. When asked to describe the position of Resident # 50's heels, CNA # 3 stated, "They are on the bed." When asked what position the heels should be in, CNA # 3 stated, "Off the bed" and immediately repositioned Resident # 50's feet and legs so the heels were elevated.

On 10/23/19 08:28 a,m. an observation of Resident # 50 was conducted with CNA # 1. Resident # 50 was observed lying in bed with his legs covered by a blanket. Resident #50 was asked if this surveyor could look at his feet with the assistance of CNA # 1. Resident # 50 stated, "Yes." CNA # 1 removed the blanket exposing Resident # 50's feet and lower legs [below the knees]. Observation of Resident # 50's lower legs revealed a cushion and pillow under both

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calves. Observation of Resident # 50 right and left heels revealed they were resting directly on the bed. When asked to describe the position of Resident # 50's heels, CNA # 1 stated, "They are on the bed." When asked what position the heels should be in, CNA # 1 stated, "Off the bed" and immediately repositioned Resident # 50's feet and legs so the heels were elevated. When asked to describe the procedure for positioning a resident CNA 1 stated, "They should be repositioned every 2 hours and as needed.

On 10/23/19 at 2:50 p.m. an interview was conducted with the ADON (assistand Director of nursing), RN(registered nurse) #3, regarding the above observations and Resident # 50's care plan. RN # 3 was asked if the care plan was being implemented. RN # 3 stated, "No."

On 10/24/19 at 12:10 p.m., ASM [administrative staff member] # 1, executive director and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread This information was obtained from the website: https://medlineplus.gov/paralysis.html.

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F 656	Continued From page 70 [2] A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		11/29/19

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F 657	Continued From page 71 by: Based on observation, resident interview, staff interview and facility document review it was determined facility staff failed to accurately revise the care plan for two of 47 residents in the survey sample, Resident #31. The facility staff failed to review and revise the comprehensive care plan upon readmission to the facility for Resident #31 to address the discontinuation of oxygen and for #23 to address the use of a spirometer. The findings include: 1. The facility staff failed to revise the comprehensive care plan for Resident #31 after a readmission on 10/15/19 to address the discontinuation of oxygen. Resident #31was admitted to the facility on 08/09/2019 with a readmission on 10/15/2019 with diagnoses that included but were not limited to chronic respiratory failure (1) and traumatic brain injury (2). Resident #31's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 08/09/19, coded Resident #31 in a persistent vegetative state/no discernible consciousness. The comprehensive care plan "The resident at risk for altered respiratory status/difficulty breathing r/t (related to) Chronic raspatory [sic] Failure, Hx (history) of Bronchitis (3), Date Initiated: 10/16/2019; Revision on: 10/16/2019." Under "Interventions/Tasks" it documented, "Oxygen Settings: 2 (two) liters with humidification via trach (tracheostomy) (4) collar (mask). Date Initiated: 10/16/2019; Revision on	F 657	1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? -On 10/24/2019, MDS Coordinator reviewed and revised the readmission respiratory comprehensive care plan for resident #31 to reflect resident no longer utilizing oxygen therapy, and resident #23 to reflect use of incentive spirometer. The rest of their care plan was revised appropriately upon readmission. 2. How will the facility identify other residents having the potential to be affected by the same practice? -All residents have the potential to be affected by deficient practice if any part of their patient centered care plan is not revised to reflect changes to their current care. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? -By 11/25/2019, Staff Development Coordinator or Designee will re-educate licensed nurses on revision of care plans to reflect changes to residents current care. Any licensed nurse that has not completed re-education by 11/25/2019, will not be allowed to work until re-education is completed. All newly hired staff will receive education during orientation on facility policy "Care	

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F 657	Continued From page 72 10/16/2019." On 10/22/19 at approximately 1:45 p.m., an observation was conducted of Resident #31 in her room. Resident #31 was lying in bed on her left side facing the window with her eyes closed. The head of the bed was observed to be elevated at a 45 degree angle. Resident #31 was not observed wearing any oxygen. Observation of Resident #31's room failed to evidence any oxygen equipment. Additional observations on 10/23/19 at approximately 9:00 a.m. and 10/24/19 at approximately 8:45 a.m. revealed Resident #31 not wearing any oxygen and failed to evidence any oxygen equipment in the room. Review of Resident #31's clinical record failed to evidence documentation of Resident #31 receiving oxygen since readmission to the facility on 10/15/19 after a facility initiated transfer on 10/11/19. On 10/24/19 at 9:10 a.m., an interview was conducted with RN (registered nurse) #3, the assistant director of nursing. When asked how often the care plan is reviewed and updated, RN #3 stated that it is updated with any changes, quarterly, annually and with new orders. When asked if a readmission warrants a care plan update, RN #3 stated, "Yes." When asked about the readmission on 10/15/19 for Resident #31, RN #3 stated that the care plan should be updated with the date of her readmission. When asked if Resident #31 is currently using oxygen, RN #3 stated that she is not. RN #3 stated that the tracheostomy was removed when Resident #31 was sent to the hospital and that the stoma	F 657	Planning and Interventions". -All previous day orders and readmssions will be reviewed in daily grand rounds 5 days per week by MDS Coordinator or Designee to validate proper revision of care plan reflects changes to current care needs. Audit will occur 5x/week x30 days, 3x/week x30 days, and 1x/week x30 days. 4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccurring? -Director of Nursing will present findings of audit to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. QAPI committee consists of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Manager, Pharmacy Consultant, and Medical Director.	

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(surgical opening) has closed. When asked if Resident #31 has used oxygen at since being readmitted to the facility, RN #3 stated "No." After reviewing the care plan "The resident at risk for altered respiratory status/difficulty breathing ...Date Initiated: 10/16/2019; Revision on: 10/16/2019" with the documented intervention for "Oxygen Settings: 2 (two) liters with humidification via trach (tracheostomy) (4) collar (mask). Date Initiated: 10/16/2019; Revision on 10/16/2019", RN #3 stated that the oxygen should not be there. RN #3 stated that the care plan had been updated on readmission but the oxygen had not been taken off. RN #3 stated that Resident #31 no longer uses oxygen and no longer has the tracheostomy and that the care plan had been updated this morning to reflect this.

On 10/24/19 at 9:30 a.m., an interview was conducted with LPN (licensed practical nurse) #4, the MDS (minimum data set) coordinator. When asked how often care plans are updated LPN #4 stated that they are updated quarterly and when a significant change occurs. When asked if a readmission is a significant change LPN #4 stated "Yes." When asked about the care plan for Resident #31 LPN #4 stated that the oxygen at 2 liters via trach collar should have come off of the care plan when Resident #31 was readmitted. LPN #4 stated that the resident came back to the facility without the tracheostomy and the oxygen.

A review of the facility policy, "Care Planning and Intervention" documented, "The care plan is updated as needed, but no less than quarterly as: conditions change. Goals are met. Interventions are determined to be ineffective or need to be revised."

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On 10/24/19 at approximately 12:15 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the above concern.

No further information was presented prior to exit.

References:

1. Respiratory failure
Respiratory failure is a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide. Sometimes you can have both problems. When you breathe, your lungs take in oxygen. The oxygen passes into your blood, which carries it to your organs. Your organs, such as your heart and brain, need this oxygen-rich blood to work well. Another part of breathing is removing the carbon dioxide from the blood and breathing it out. Having too much carbon dioxide in your blood can harm your organs. This information was obtained from the website:
https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=respiratory+failure&_ga=2.10765815.252353412.1572267082-1838772440.1562936034

2. Traumatic brain injury- Happens when a bump, blow, jolt, or other head injury causes damage to the brain. Symptoms of a TBI may not appear until days or weeks following the injury. This information was obtained from the website:
https://medlineplus.gov/traumaticbraininjury.html

3. Chronic bronchitis- An inflammation of the bronchial tubes, the airways that carry air to your lungs. It causes a cough that often brings up

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mucus. This information was obtained from the website: https://medlineplus.gov/chronicbronchitis.html

4. Tracheostomy - A surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube. This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm.

2. The facility staff failed to review and revise the comprehensive care plan to included the use of the incentive spirometer (1) for Resident #23 as documented on the discharge "After Visit Summary" from "[Name of Hospital]" on readmission.

Resident #23 was admitted to the facility on 4/26/2019 with a readmission on 10/18/2019, with diagnoses that included but were not limited to sepsis (2), and orthopedic (3) aftercare. Resident #23's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/03/19, coded Resident #23 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions.

On 10/22/19 at approximately 2:30 p.m., an interview was conducted with Resident #23. Resident #23 was observed sitting in the wheelchair beside the bed wearing an oxygen cannula. An incentive spirometer was observed on the bedside table in front of Resident #23. When asked about the incentive spirometer on

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the table, Resident #23 stated that it was given to her when she was at the hospital the prior week for hip surgery. When asked if the staff assist her with using it, Resident #23 stated that she does it herself most of the time five or six times a day. When asked if the staff know that she is using the incentive spirometer, Resident #23 stated, "Yes, some of them help me."

The comprehensive care plan for Resident #23 dated 10/23/2019 failed to evidence documentation for use of the incentive spirometer.

The document "Discharge Summary; After Visit Summary" provided by the discharging provider on 10/18/2019 documented the following for Resident #23.
- "This after visit summary contains important discharge instructions related to your care after discharge from the hospital."
- "Additional instructions as follows: Use Incentive Spirometer every hour while awake."

On 10/23/19 at 4:35 p.m., an interview was conducted with RN (registered nurse) #5. When asked about the incentive spirometer for Resident #23, RN #5 stated that it was brought back from the hospital last Tuesday when the resident had a surgery performed. When asked if Resident #23 uses the incentive spirometer, RN #5 stated, "Yes, she does." When asked if it is documented how often, the resident uses the incentive spirometer, RN #5 stated that there was no official order and they do not document when she uses it. When asked how the staff knows when and if the resident is using the incentive spirometer as instructed, RN #5 stated that the resident is alert and oriented and she does the

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incentive spirometer herself. When asked if the practice is to have an order and care plan in place for an incentive spirometer, RN #5 stated that they have never had orders for them before or put them on care plans in the past that she is aware of.

On 10/24/19 at 11:20 a.m., an interview was conducted with RN (registered nurse) #3. When asked the process for transcribing orders from the hospital, RN #3 stated that the discharge summary is utilized. RN #3 stated that the physician or nurse practitioner is called and the discharge summary is reviewed with them, the orders are received, reviewed and then transcribed into the computer where a physician order summary is printed off. The nurse checks the orders again for accuracy. When asked if the nurse uses the after visit summary as part of the discharge orders, RN #3 stated, "Yes, the nurse looks at it for follow up appointment information." After reviewing the after visit summary for Resident #23 dated 10/18/19, RN #3 stated that the incentive spirometry was not transcribed to the physician order summary although the other orders including the TED hose and the dressing change instructions were. RN #3 stated that they have never put orders in for incentive spirometers in the past and that most residents do not have them. When asked if the incentive spirometer should have been on the physician order summary, RN #3 stated that she was not sure, it has never been their practice. When asked what the purpose of an incentive spirometer is, RN #3 stated that it is a piece of equipment used after surgery to expand the lungs and prevent atelectasis (lung collapse). When asked how often the care plan is updated RN #3 stated that it is updated with any changes, quarterly, annually

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and with new orders. When asked if other respiratory treatments are included on the care plan, RN #3 stated, "Yes." When asked what standard of practice is used at the facility, RN #3 stated the facility policies and Lippincott.

The facility's policy "Care Planning and Interventions" documented in part, "The Care Plan addresses, to the extent possible: Interventions for preventing avoidable declines in functioning or functional levels; Treatment objectives with measurable outcomes; Parameters for monitoring;"

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

On 10/24/19 at approximately 12:15 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. Incentive spirometer is a device used to help you keep your lungs healthy after surgery or when

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F 657	Continued From page 79 you have a lung illness, such as pneumonia. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm 2. Sepsis is an illness in which the body has a severe, inflammatory response to bacteria or other germs. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm. 3. Orthopedic or orthopedic services, aim at the treatment of the musculoskeletal system. This includes your bones, joints, ligaments, tendons, and muscles. This information was obtained from the website: https://medlineplus.gov/ency/article/007455.htm	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview and facility document review it was determined facility staff failed to follow professional standards of care for transcribing orders from the discharge after visit instructions received from the hospital for one of 47 residents in the survey sample, Resident #23. The facility staff failed to transcribe the order for hourly incentive spirometer use while awake for Resident #23 as documented on the "After Visit Summary" received from "[Name of Hospital]."	F 658	1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? -On 10/24/2019, nurse obtained and transcribed order for incentive spirometer use for resident #23. 2. How will the facility identify other residents having the potential to be	11/29/19

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F 658	Continued From page 80 The findings include: Resident #23 was admitted to the facility on 4/26/2019 with a readmission on 10/18/2019, with diagnoses that included but were not limited to sepsis (1), and orthopedic (2) aftercare. Resident #23's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/03/19, coded Resident #23 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions. On 10/22/19 at approximately 2:30 p.m., an interview was conducted with Resident #23. Resident #23 was observed to be sitting in the wheelchair beside the bed wearing an oxygen cannula. An incentive spirometer (3) was observed on the bedside table in front of Resident #23. When asked about the incentive spirometer on the table Resident #23 stated that it was given to her when she was at the hospital the prior week following hip surgery. When asked if the staff assist her with using it Resident #23 stated that she does it herself five or six times a day. When asked if the staff know that she is using the incentive spirometer Resident #23 stated, "Yes." When asked if the staff assist her to use it Resident #23 stated, "Sometimes they do." The physicians "Order Summary Report" dated "Oct (October) 21, 2019" and "Oct 24, 2019" for Resident #23 failed to evidence documentation of an active order for the incentive spirometer use. The document "After Visit Summary" from "[Name of Hospital]" provided by the discharging	F 658	affected by the same practice? -All residents with physician orders have the potential to be affected by the deficient practice. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? -By 11/25/2019, Staff Development Coordinator or Designee will re-educate licensed nurses on transcribing physician orders. Any licensed nurse that has not completed re-education by 11/25/2019, will not be allowed to work until re-education is completed. All newly hired staff will receive education during orientation on facility policy "Physician Order Processing Procedure". -Director of Nursing or Designee will validate all orders 5x/week x30 days, 3x/week x30 days, and 1x/week x30 days to validate accuracy and ensure licensed nurses followed Physician Order Processing Procedure including orders being checked by a 2nd nurse and night shift nurse 24 hour chart checking. -Director of Nursing or Designee will review all new admission/readmission discharge orders to facility Physician Order Sheets to validate accuracy and ensure licensed nurses followed Physician Order Processing Procedure including orders being checked by a 2nd nurse and night shift nurse 24 hour chart checking. Audit will occur 5x/week x30 days, 3x/week x30 days, and 1x/week x30 days.	

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F 658	Continued From page 81 provider on 10/18/2019 documented the following in part for Resident #23. - "Discharge instructions, This after visit summary contains important discharge instructions related to your care after discharge from the hospital." - "Additional instructions as follows: Use Incentive Spirometer every hour while awake. Wear your TED (thrombo-embolic-deterrent) hose (worn to prevent blood clots) during the day, off at night. Leave Aquacel (sterile medicated wound dressing) dressing in place for 7 (seven) days ..." The eTAR (electronic treatment administration record) dated "10/1/2019-10/31/2019" documented, "Left hip aquacel: Leave in place for 7 (seven) days ...Order Date 10/18/2019; TED hose on every AM (morning) and off every PM (evening) Order Date 10/18/2019." Further review of the eTAR failed to evidence documentation of the incentive spirometer. The comprehensive care plan for Resident #23 dated 10/23/2019 failed to evidence documentation of the use of an incentive spirometer. On 10/23/19 at 4:35 p.m., an interview was conducted with RN (registered nurse) #5. When asked about the incentive spirometer for Resident #23 RN #5 stated that it was brought back from the hospital last Tuesday when the resident had a surgery performed. When asked if Resident #23 uses the incentive spirometry RN #5 stated, "Yes, she does." When asked if it is documented how often the resident uses the incentive spirometer RN #5 stated that there was no official order and they do not document when she uses it. RN #5 was asked how staff would know how often and if the resident is to use the incentive, spirometer as	F 658	4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccurring? -Director of Nursing will present findings of audit to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. QAPI committee consists of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Manager, Pharmacy Consultant, and Medical Director.	

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instructed. RN #5 stated that the resident is alert and oriented and she does the incentive spirometer herself. When asked if the practice is to have an order in place for an incentive spirometer RN #5 stated that she was not aware of orders for them before in the past.

On 10/24/19 at 11:20 a.m., an interview was conducted with RN (registered nurse) #3, the assistant director of nursing. When asked the process for transcribing orders from the hospital RN #3 stated that the discharge summary is utilized. RN #3 stated that the physician or nurse practitioner is called and the discharge summary is reviewed with them, the orders are received, reviewed and then transcribed into the computer where a physician order summary is printed off. The nurse checks the orders again for accuracy. When asked if the nurse uses the after visit summary as part of the discharge orders RN #3 stated, "Yes, the nurse looks at it for follow up appointment information." After reviewing the after visit summary for Resident #23 dated 10/18/19 RN #3 stated that the incentive spirometry was not transcribed to the physician order summary although the other orders including the TED hose and the dressing change instructions were. RN #3 stated that they have never put orders in for incentive spirometers in the past. When asked if the incentive spirometry should be on the physician order summary, RN #3 stated that she was not sure, it has never been their practice. When asked what the purpose of an incentive spirometer, RN #3 stated that it is a piece of equipment used after surgery to expand the lungs and prevent atelectasis (lung collapse). When asked if other respiratory treatments have orders placed for them RN #3 stated, "Yes." When asked what standard of

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practice is used at the facility RN #3 stated the facility policies and Lippincott.

The facility's policy "Physician Order Processing Procedure- Electronic Process, Effective Date: 4/10/19" documented in part, "Admission orders are received prior to or upon each admission or readmission. Orders may be written by the physician, nurse practitioner or physician's assistant; obtained via (by way of) telephone by the nursing staff from the physician, or transcribed from the transfer orders."

The facility's policy "Physician Orders, Last Revised: 1/2018" documented in part, "Physician orders include the following. Medications and Treatments ...Special medical procedures required for the safety and well-being of the resident." The policy further documented, "Note: Medications, diets, therapy, and any treatment may not be administered to the resident without a written order form the attending physician."

According to "Fundamentals of Nursing- Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished. Be sure to look for order duplications that could cause your patient to receive a medication in error...."

On 10/24/19 at approximately 12:15 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

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F 658	Continued From page 84 Reference: 1. Sepsis is an illness in which the body has a severe, inflammatory response to bacteria or other germs. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm. 2. Orthopedics or orthopedic services, aim at the treatment of the musculoskeletal system. This information was obtained from the website: https://medlineplus.gov/ency/article/007455.htm 3. Incentive spirometer- An incentive spirometer is a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm	F 658		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure	F 684	1. How will the corrective action be accomplished for those residents found to have been affected by the deficient	11/29/19

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that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan for three of 47 residents in the survey sample, Resident #20, Resident #44 and Resident. On 10/11/19, a wound care specialist treated Resident #20. The facility did not act on the specialist's recommendations until 10/14/19, even though a facility staff member was in possession of the wound specialist's report/recommendation on the afternoon of 10/11/19. Staff also failed to monitor Resident #20's fluid intake as ordered by the physician on multiple shifts during September 2019 and October 2019 and the staff failed to look at Resident #44's abdominal binder every 30 minutes and failed to loosen the abdominal binder every two hours per physician orders.

The findings include:

1. a. Resident #20 was admitted to the facility on 4/19/18, and most recently readmitted on 9/5/19 with diagnoses including, but not limited to ESRD (end stage renal disease) (1) and COPD (chronic obstructive pulmonary disease) (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 7/26/19, Resident #20 was coded as being cognitively intact for making daily decisions, have scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as having a wound that was not a pressure ucler, and as having received dialysis during the look back period.

A review of Resident #20's clinical record revealed a physician's order dated 9/6/19, that was discontinued on 10/14/19: "Cleanse left heel

practice?

-Resident #20 - On 10/24/2019, wound clinic consults were reviewed and validated to be correct and present in medical record.

-Resident #44, on 10/24/2019, staff working with resident were demonstrated how to loosen and check abdominal binder with reminder of frequency of checks as indicated on the care plan. On 11/11/2019, kardex was reviewed to ensure loosening protocol and duration timeframes.

-Resident #20, on 10/24/2019, staff working with resident were reminded of fluid intake documentation as indicated on care plan.

2. How will the facility identify other residents having the potential to be affected by the same practice?

-All residents have the potential to be affected by the deficient practice if any of their orders are not followed.

3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur?

By 11/22/2019, facility will implement process for outside consultation communication.

-By 11/25/2019, Staff Development Coordinator or Designee will educate staff

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F 684	Continued From page 86 with NS (normal saline), pat dry, and apply wet-to dry dressing. Cover with dry gauze, wrap with kerlix (gauze wrap) and ace wrap twice daily." Further review of the record revealed the following order dated 10/14/19: "Clean left heel with normal saline, pat dry and apply hydrofera blue transfer foam kling and tape three times a week, every day shift every Monday, Wednesday, and Friday." A review of Resident #20's progress notes revealed the following nurse's note written 10/12/19 at 9:17 a.m.: "Orders - Administration Note: Cleanse left heel with NS, pat dry, and apply wet-to-dry dressing, cover with dry gauze, wrap with kerlix, and ace wrap twice daily...Resident states that wound center told him dressing is to be changed 3X/week (three times a week) and that they would fax orders to facility. No new orders received resident declined dressing change." A review of Resident #20's progress notes revealed the following nurse's note dated 10/12/19 at 10:01 p.m.: "Orders - Administration Note: Cleanse left heel with NS, pat dry, and apply wet-to-dry dressing, cover with dry gauze, wrap with kerlix, and ace wrap twice daily. /refused drsg (dressing) change. Stated it was not due today." A review of Resident #20's progress notes revealed the following nurse's note dated 10/13/19 at 9:32 p.m.: "Orders - Administration Note: Cleanse left heel with NS, pat dry, and apply wet-to-dry dressing, cover with dry gauze, wrap with kerlix, and ace wrap twice daily. States dressing is not to be chaned (sic) yet."	F 684	on outside consultation communication process and "Care Planning and Interventions", and implementing physician orders. Any licensed nurse or certified nursing assistant that has not completed re-education by 11/25/2019, will not be allowed to work until re-education is completed. All newly hired staff will receive education during orientation on facility policy "Care Planning and Interventions" and utilizing the kardex and outside consultation communication process . -Director of Nursing or Designee will validate orders being followed and implementation of care plan approaches of 10 different residents 5 times per week x30 days, 3 times per week x30 days, and 1 time per week x30 days. -Director of Nursing or Designee will validate all residents that attend outside consultation for recommendations properly and timely called to MD/NP for implementation. 4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccurring? -Director of Nursing will present findings of audit to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. QAPI committee consists of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services,	

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F 684	Continued From page 87 A review of Resident #20's progress notes revealed the following nurse's note dated 10/14/19 at 12:46 p.m.: "Wound center returned call back with clarification with dressing changes. Should be cleaned with normal saline then apply hydrofera blue transfer foam kling and tape. Change three times a week." A review of Resident #20's comprehensive care plan dated 9/16/19 revealed, in part, the following: "At risk for break in skin integrity; Resident has left heel wound...Treatment as ordered." On 10/24/19 at l0:10 a.m., LPN (licensed practical nurse) #5 was interviewed. When asked about the above-referenced orders and communication from the wound care center, physician for Resident #20, LPN #5 stated, "Usually they come back from the wound center with a consult sheet. The sheet contains any new orders and we take the orders from the consult sheet and call the attending physician. Once they are approved, we start the treatment." When asked if a resident should wait three days before new wound care orders are implemented, LPN #5 stated, "No. It should happen pretty much right away." On 10/24/19 at 10:45 a.m., OSM (other staff member) #10, the transportation coordinator, provided the surveyor with a copy of the wound care consultation, report for Resident #20 from 10/11/19. The fax date stamp at the top of the page was 10/11/19 at 2:33 p.m. Under the Recommendations section, the report documented: "Cleanse left heel wound with normal saline then apply hydrofera blue transfer foam, kling wrap, and tape. Change three times a week." When asked where she got this report,	F 684	Dietary Manager, Pharmacy Consultant, and Medical Director.	

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OSM #10 stated, "It was downstairs in my office. They always fax me so I know when to set up the transportation for the next appointment." When asked if she ever shares the faxes with the nursing staff, OSM #10 stated, "No, because they get their own."

On 10/24/19 at 11:13 a.m., RN (registered nurse) #3, the ADON (assistant director of nursing) was interviewed. She stated the process is for residents to return from outside appointments with a consult report with them. She stated the nurse is responsible for taking care of any new orders. She further stated that on 10/11/19, Resident #20 had gone straight from the wound care physician to dialysis, and that Resident #20 had returned late in the day back to the facility. RN #3 stated that there was no wound care consult, report anywhere in the record for 10/11/19, and that Resident #20 must have returned from dialysis without the wound care consult, report. RN #3 stated that it was so late in the day (a Friday evening) that the wound care center would have been closed, and that no information would have been available about Resident #20's appointment until Monday morning, 10/14/19. At this time, RN #3 was informed about OSM #10 having the faxed wound care report.

On 10/24/19 at 11:27 a.m., RN #3, returned and stated, "I have been looking into this. I just now found out that the wound center also faxes the transport driver with the consultation reports. I didn't know that. I don't know how we are supposed to know that there is another fax. I don't know how the nurses are supposed to know that there is another fax somewhere in the building. Our hands were tied when the resident

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returned to the building too late for us to call the wound center." When asked if she could foresee a concern related to this lack of communication if a resident was not cognitively intact and could not speak up to tell the facility staff that there should be new orders, RN #3 stated, "Yes".

On 10/24/19 at 11:00 a.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. A facility policy regarding outside consultation communication/coordination was requested.

On 10/24/19 at 1:23 p.m., ASM #2 stated the facility did not have a policy on outside consultation communication/coordination.

References:
(1) "End-stage kidney disease (ESKD) is the last stage of long-term (chronic) kidney disease. This is when your kidneys can no longer support your body's needs. End-stage kidney disease is also called end-stage renal disease (ESRD)." This information is taken from the website https://medlineplus.gov/ency/article/000500.htm.

(2) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.

(3) "Absorptive dressing combines two organic pigments (methylene blue and gentian violet) to create a wound environment that is prime for healing; suitable for use on partial and full thickness wounds." This information is taken from

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the website https://www.medline.com/product/Hydrofera-Blue-Ready-Transfer-Foam-Dressings-by-Hydrofera/Z05-PF184203.

1. b. The facility staff failed to monitor Resident #20's fluid intake as ordered by the physician on multiple shifts during September 2019 and October 2019.

A review of Resident #20's clinical record revealed the following physician's order, dated 9/5/19: "Fluid Restriction 1500 ml/day (milliliters per day). From Kitchen: Breakfast 720 ml, Lunch 240 ml, dinner 240 ml. From Nursing Days 150 ml, eves (evenings) 150 ml) nights 0 ml. Every shift document amount consumed."

A review of Resident #20's September 2019 and October 2019 MARs (medication administration records revealed blanks on the following days in the space where the fluid restriction enforcement should have been documented: 9/7/19 day shift, 9/8/19 day shift, 9/9/19 day shift, 9/12/19 day and evening shifts, 9/19/19 evening shift, 9/21/19 day and evening shifts, 9/24/19 evening shift, 9/30/19 evening shift, 10/1/10 evening shift, 10/8/19 evening shift, 10/15/19 evening shift, and 10/18/19 day shift.

A review of Resident #20's comprehensive care plan dated 9/16/19 revealed, in part, the following: "Dialysis r/t related to) renal (kidney) failure...Fluid restriction as ordered."

On 10/24/19 at 9:01 a.m., LPN (licensed practical nurse) #1 was interviewed. She stated she is not familiar with Resident #20's care. When shown

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the above-referenced MARs containing the blanks for the fluid restriction documentation, and when asked what these blanks mean, LPN #1 stated, "I don't want to say what I think it means. Because I think, it's not good. I need to find out."

On 10/24/19 at 10:07 a.m., LPN #5 was interviewed. She stated she was very familiar with Resident #20's care. When asked why Resident #20 was on a fluid restriction, LPN #5 stated, "He is a dialysis patient. Typically, they have some kind of fluid restriction." When asked what she knew about Resident #20's restrictions, LPN #5 stated, "His fluid intake is monitored every shift. We keep track of what the resident takes in. Sometimes the aides record it and sometimes I record it. But at the end of the shift, there is a box for me to add up all the totals and sign off on the total." When shown the MARs referenced above for Resident #20, and when directed to the blank spots, LPN #5 was asked what the blank spots mean. LPN #5 stated, "If a box is not signed off and totaled, I can't tell how much he got. There is no way to tell. There is no way to know how much he would be allowed to have for the rest of the day. I can't see how anybody would miss that." When asked what the lack of documentation meant, LPN #5 stated, "Well, if it's not documented, I can only imagine it wasn't done. It doesn't look like anybody kept up with his fluid on those shifts."

On 10/24/19 at 11:00 a.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy, "Fluid Restrictions," revealed, in part, the following: "Fluid restrictions

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are coordinated between Nursing Services and Food and Nutrition Services...The fluid restriction is noted on the tray card and clearly identifies the type and amount of fluids to be served."

No further information was provided prior to exit.

2. The faciity staff failed to look at Resident #44's abdominal binder every 30 minutes and failed loosen the abdominal binder every two hours per physician orders.

Resident #44 was admitted to the facility on 8/8/18, and most recently readmitted on 5/2/19, with diagnoses that include, but are not limited to, history of a stroke, obstructive uropathy (1) and dementia with behaviors (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 9/3/19, Resident #44 was coded as being severely cognitively impaired for making daily decisions, having scored five out of 15 on the BIMS (brief interview for mental status). He was coded as having an indwelling catheter in his bladder, and as having a physical restraint on a daily basis.

On 10/23/19 from 1:51 p.m. until 4:01 p.m., (135-minute period), two surveyors continuously observed Resident #44. During this time, Resident #44 was positioned in a reclining chair across from a nurses' station, just outside the main dining room. Resident #44's legs, torso, and arms were covered with a blanket. At no time during this observation did any staff member look underneath the blanket to verify the position of or to loosen Resident #44's abdominal binder, worn under his shirt.

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A review of Resident #44's clinical record revealed the following physician's order dated 8/21/19: "Abdominal binder: Check abdominal binder every 30 minutes and release every 2 hours every shift for safety, to keep resident from pulling at suprapubic catheter (3)."

A review of Resident #44's comprehensive care plan dated 8/28/19 revealed, in part, the following: "The resident uses abdominal binder for suprapubic cath (catheter). The resident will remain free of complications related to restraint use, including contractures, skin breakdown, altered mental status, isolation, or withdrawal through review date...Alternatives to abdominal binder was ABD (abdominal) pad and tape, but resident started pulling at suprapubic catheter; therefore abdominal binder was reinstated...RESTRAINT USE: Apply abdominal binder, check every 30 minutes and release every 2 hours."

On 10/24/19 at 9:03 a.m., LPN (licensed practical nurse) #1 was interviewed. When asked if she had taken care of Resident #44 on 10/23/19, LPN #1 stated, "Yes I did." When asked what restraint Resident #44 used, LPN #1 stated, "He has an abdominal binder. He has a suprapubic catheter. Without the binder, he will rip [the catheter] out. He has pulled it out before and had to go back to have it replaced. That's why he has the binder." When asked what orders accompany the use of the abdominal binder, LPN #1 stated, "We are supposed to check it every 30 minutes." When asked what "checking" the binder means, LPN #1 stated, "We are supposed to actually look at it. That's all, I think." When asked if she was aware of anything that needed to be done every two

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LIFE CARE CENTER OF NEW MARKET	315 EAST LEE HIGHWAY NEW MARKET, VA 22844

(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 684	Continued From page 94	F 684		

hours, LPN #1 stated, "No. I'm not familiar with anything else." LPN #1 was asked to review the physicians' orders for Resident #44. After reviewing the physician's orders, LPN #1 stated, "We are supposed to loosen it every two hours." When asked if she had looked at Resident #44's abdominal binder every 30 minutes on 10/23/19, LPN #1 stated, "No, I didn't." When asked if she loosened the resident's abdominal binder every two hours on 10/23/19, LPN #1 stated, "No, I didn't do that either. I'm sorry." When asked why looking at the binder every 30 minutes and loosening the binder every two hours are important actions to take, LPN #1 stated, "We need to make sure it is in the right place. There was a time when one of the binders we had was digging into him. This would let us see underneath it every now and then."

On 10/24/19 at 11:00 a.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy, "Restraint and Position Change Alarm Use," revealed, in part, the following: "A physician's order is required for the use of the specific type of restraint. The order should include the specific type of restraint, the condition and/or medical symptom that warrants restraint use, where and how the restraint is to be applied and used, and the time and frequency the restraint should be released...The use of the restraint must be individualized and must be based upon the resident's condition and medical symptoms that must be treated. The care plan is revised as needed and must include...The time and frequency the restraint should be released; the type of specific direct monitoring and

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F 684	Continued From page 95 supervision provided during the use of the restraint." No further information was provided prior to exit. (1) "Obstructive uropathy is a condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys." This information is taken from the website https://medlineplus.gov/ency/article/000507.htm. (2) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm. (3) "A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly. You may need a catheter because you have urinary incontinence (leakage), urinary retention (not being able to urinate), surgery that made a catheter necessary, or another health problem." This information is taken from the website https://medlineplus.gov/ency/patientinstructions/000145.htm.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		11/29/19

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F 690	Continued From page 96 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that facility staff failed to provide care and services for an indwelling catheter to prevent urinary tract infections for one of 40 residents in the survey sample, Residents # 49. The facility staff failed to maintain Resident # 49 catheter tubing off the floor while he was sitting in his wheelchair.	F 690	1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? -On 10/24/2019, nurse placed tubing appropriately when notified for resident #49. -On 11/11/2019, resident #49 was assessed for use of a leg bag for urine	

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F 690	Continued From page 97 The findings include: Resident # 49 was admitted to the facility on 04/09/2019 with diagnoses that included but were not limited to Parkinson's disease [1], obstructive and reflux uropathy [2] and anxiety [3]. Resident # 49's most recent MDS (minimum data set), an quarterly assessment with an ARD (assessment reference date) of 09/06/19, coded Resident # 49 as scoring a four on the brief interview for mental status (BIMS) of a score of 0 - 15, four - being severely impaired of cognition for making daily decisions. Resident # 49 was coded as requiring extensive assistance of one staff member for all activities of daily living. Section H "Bladder and Bowel" coded Resident # 50 as having an indwelling catheter [2]. The POS [physician's order sheet] for Resident # 39 dated) CT [October] 2019" documented, "Catheter Care every shift and p.m. every shift for PREVENTION. Date Ordered: 06/19/2019." The comprehensive care plan for Resident # 49 dated 06/08/2019 documented, "Focus. Resident has an indwelling catheter: Urinary retention r/t [related to] obstructive uropathy. Date Initiated: 06/08/2019." On 10/22/19 at 1:57 p.m., Resident # 49 was observed in his wheelchair engaged in an "Ice Cream Social" in the facility's activity room. Observation of Resident # 49's catheter collection bag revealed it was hanging under the wheelchair in a privacy bag. Observation of the catheter tubing revealed it was resting directly on the floor under the wheelchair. Further observation revealed Resident # 49's right foot resting on the	F 690	drainage from indwelling foley catheter while up in wheelchair. 2. How will the facility identify other residents having the potential to be affected by the same practice? -All residents with indwelling foley catheters have the potential to be affected by this practice. *By 11/15/2019, Director of Nursing or designee will review all residents with indwelling foley catheters and assess for leg bag usage versus larger drainage bag while up in wheelchair. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? -By 11/25/2019, Staff Development Coordinator or Designee will educate licensed nurses on chapter 21 of Lippincott Manual, including assessing for leg bag usage versus drainage bag while up in wheelchair. Any licensed nurse that has not completed education by 11/25/2019, will not be allowed to work until education is completed. All newly hired staff will receive education during orientation on chapter 21 of Lippincott Manual, including assessing for leg bag usage versus drainage bag while up in wheelchair. -Director of Nursing or Designee will review all resident's with foley catheters for leg bag usage while up in wheelchair 5x/week x30 days, 3x/week x30 days, and	

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F 690	Continued From page 98 tubing, putting the tubing between the bottom of his foot and the floor. On 10/22/19 at 2:25 p.m., Resident # 49 was observed being pushed down the hallway in his wheelchair. Observation of the wheelchair revealed the catheter collection bag was hanging under the wheelchair in a privacy bag. Observation of the catheter tubing revealed it was rubbing on the floor under the wheelchair as Resident # 49 was being pushed down the hall. On 10/23/19 at 4:10 p.m., Resident # 49 was observed sitting in his wheelchair in the hallway in front of the nurse's station. Observation of Resident # 49's catheter collection bag revealed it was hanging under the wheelchair in a privacy bag. Observation of the catheter tubing reveal it was resting directly on the floor under the wheelchair. Further observation revealed Resident # 49's right foot resting on the tubing, putting the tubing between the bottom of his foot and the floor. On 10/24/19 at 8:40 a.m., an interview was conducted with CNA [certified nursing assistant] # 1. When asked to describe how a resident's catheter collection bag and catheter tubing should be positioned when a resident is in a wheelchair, CNA # 1 stated, "The bag should be in a privacy bag and the tubing and the bag should not be touching the floor." When asked why the bag and tubing should not be touching the floor, CNA # 1 stated, "To prevent infection." When asked who was responsible for ensuring the catheter bag and tubing are not in contact with the floor, CNA # 1 stated, "Any nursing staff." When asked how often staff check the position of the catheter bag and tubing, CNA # 1 stated, "Every two hours and	F 690	1x/week x30 days. 4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccurring? -Director of Nursing will present findings of audit to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. QAPI committee consists of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Manager, Pharmacy Consultant, and Medical Director.	

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as needed."

On 10/24/19 at 8:45 a.m., an interview was conducted with CNA # 2. When asked to describe how a resident's catheter collection bag and catheter tubing should be positioned when a resident is in a wheelchair CNA # 2 stated, "The bag should be in a privacy bag and the tubing and the bag should not be touching the floor." When asked why it should not be touching the floor CNA # 2 stated, "To prevent infection."

On 10/24/19 at 8:50 a.m., an interview was conducted with LPN [licensed practical nurse # 1, regarding how a resident's catheter collection bag and catheter tubing should be positioned when a resident is in a wheelchair. LPN # 1 stated, "The bag should be in a privacy bag and the tubing and the bag should not be touching the floor." When asked why the Foley catheter bag and tubing should not be touching the floor, LPN # 1 stated, "To prevent it from leaking, or tearing and for infection." When asked who was responsible for ensuring the catheter bag and tubing are not in contact with the floor, LPN # 1 stated, "Any nursing staff." When asked how often the position of the catheter bag and tubing are checked, LPN # 1 stated, "Every two hours and as needed."

According to Lippincott Manual of Nursing Practice, Eighth Edition 2006, chapter 21, Renal and Urinary Disorders, page 757, "Maintaining a Closed Urinary Drainage System: Many UTI's (urinary tract infections) are due to extrinsically acquired organisms transmitted by cross-contamination. 2. c. Keep the drainage bag off the floor to prevent bacterial contamination".

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F 690	Continued From page 100 On 10/24/19 at 12:10 p.m. ASM [administrative staff member] # 1, executive director and ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. References: [1] A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. [2] A condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm. [3] Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident	F 695	1. How will the corrective action be	11/29/19

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F 695	Continued From page 101 interview and facility document review it was determined facility staff failed to provide respiratory services consistent with professional standards of practice, the comprehensive person-centered plan for one of 47 residents in the survey sample, Resident #23. The facility staff failed to provide the incentive spirometer (1) treatments every hour while awake as ordered on the "After Visit Summary" from the hospital upon readmission to the facility for Resident #23. The finding include: Resident #23 was admitted to the facility on 4/26/2019 with a readmission on 10/18/2019, with diagnoses that included but were not limited to sepsis (2), and orthopedic (3) aftercare. Resident #23's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/03/19, coded Resident #23 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions. The document "Discharge Summary; After Visit Summary" provided by the discharging provider on 10/18/2019 documented the following for Resident #23. - "This after visit summary contains important discharge instructions related to your care after discharge from the hospital." - "Additional instructions as follows: Use Incentive Spirometer every hour while awake ..." The eTAR (electronic treatment administration record) dated "10/1/2019-10/31/2019" for Resident #23 failed to evidence documentation of the incentive spirometer every hour while awake.	F 695	accomplished for those residents found to have been affected by the deficient practice? Resident #23 will be assessed for continued need of incentive spirometer. If recommended to continue, nursing documentation will include treatments as ordered by physician including the flow or volume levels, date and time of the procedure, type of spirometer, and number of breaths taken. Also record the patient's condition before and after the procedure, tolerance for the procedure, and the results of the pre-procedure and post-procedure auscultation. 2. How will the facility identify other residents having the potential to be affected by the same practice? -All residents receiving any type of respiratory care have the potential to be affected by deficient practice if respiratory care not provided in accordance with orders, care plan, and professional standards. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? -By 11/25/2019, Staff Development Coordinator or Designee will educate licensed nurses on documentation from Lippincott Manual (pg. 384). Any licensed nurse that has not completed education by 11/25/2019, will not be allowed to work until education is completed. All newly	

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F 695	Continued From page 102 On 10/22/19 at approximately 2:30 p.m., an interview was conducted with Resident #23. Resident #23 was observed to be sitting in the wheelchair beside the bed wearing an oxygen cannula. An incentive spirometer was observed on the bedside table in front of Resident #23. When asked about the incentive spirometer on the table, Resident #23 stated that it was given to her when she was at the hospital the prior week following hip surgery. When asked if the staff assist her with using it, Resident #23 stated that she does it herself five or six times a day. When asked if the staff know that she is using the incentive spirometer, Resident #23 stated, "Yes." When asked if the staff assist her to use it Resident #23 stated, "Sometimes they do." The physicians "Order Summary Report" dated "Oct (October) 21, 2019" and "Oct 24, 2019" for Resident #23 failed to evidence documentation of an active order for the incentive spirometer use. The comprehensive care plan for Resident #23 dated 10/23/2019 failed to evidence documentation of a comprehensive care plan for use of the incentive spirometer. On 10/23/19 at 4:35 p.m., an interview was conducted with RN (registered nurse) #5. When asked about the incentive spirometer for Resident #23, RN #5 stated that it was brought back from the hospital last Tuesday when the resident had a surgery performed. When asked if Resident #23 uses the incentive spirometry RN #5 stated, "Yes, she does." When asked if it is documented how often the resident uses the incentive spirometer RN #5 stated that there was no official order and they do not document when she uses it. When asked how staff know when and if the resident is	F 695	hired staff will receive education during orientation on documentation from Lippincott Manual (pg. 384). -By 11/22/2019, Director of Nursing or designee will review all residents with respiratory care orders to ensure respiratory care is being provided in accordance with orders, care plan, and professional standards. -Director of Nursing or Designee will review all resident's with respiratory care orders and evaluate accurate documentation and care plan implementation 5x/week x30 days, 3x/week x30 days, and 1x/week x30 days. 4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccurring? -Director of Nursing will present findings of audit to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. QAPI committee consists of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Manager, Pharmacy Consultant, and Medical Director.	

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using the incentive spirometer as instructed RN #5 stated that the resident is alert and oriented and she does the incentive spirometer herself.

On 10/24/19 at 11:20 a.m., an interview was conducted with RN (registered nurse) #3, the assistant director of nursing. When asked about the incentive spirometer for Resident #23 RN #3 stated that she was not aware the resident had one or was using it until today but other staff were aware. When asked if a resident has an incentive spirometer and uses it if it is documented RN #3 stated that she did not think so. RN #3 stated that they have never put orders in for incentive spirometers in the past and that most residents do not have them. When asked how staff know when the resident is using the incentive spirometer if it is not documented RN#3 stated that the situation has never come up before that she knows of. When asked what standard of practice is used at the facility RN #3 stated that they use their policies and Lippincott.

On 10/24/19 at approximately 8:30 a.m., a request was made to ASM (administrative staff member) #2, the director of nursing for the facility policy on incentive spirometry use and storage.

On 10/24/19 at approximately 12:00 p.m., the facility's policy "Oxygen Therapy- Mask & Nasal Cannula" was provided. The policy failed to evidence guidance on incentive spirometers.

According to Lippincott Nursing Procedures, Seventh edition, page 384 documented in part "Documentation ...Document the flow or volume levels, date and time of the procedure, type of spirometer, and number of breaths taken. Also record the patient's condition before and after the

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F 695	Continued From page 104 procedure, tolerance for the procedure, and the results of the preprocedure and postprocedure auscultation." On 10/24/19 at approximately 12:15 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. Reference: 1. Incentive spirometer- An incentive spirometer is a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm 2. Sepsis- An illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm. 3. Orthopedic or orthopedic services, aim at the treatment of the musculoskeletal system. This information was obtained from the website: https://medlineplus.gov/ency/article/007455.htm	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		11/29/19

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LIFE CARE CENTER OF NEW MARKET	315 EAST LEE HIGHWAY NEW MARKET, VA 22844

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F 761	Continued From page 105 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store controlled substances per regulations in one of two observed medication storage rooms, the willow medication storage room. The facility staff failed to store controlled substances in a separately locked, permanently affixed compartment. The findings include: On 10/23/19 at 10:45 a.m., observation of a medication refrigerator in the willow unit medication storage room was conducted, accompanied by LPN (licensed practical nurse)	F 761	1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? On 10/24/2019, liquid lorazepam intensol stored outside of locked compartment was secured. No resident was found to be affected by this practice. 2. How will the facility identify other residents having the potential to be affected by the same practice? -All residents living within the facility have	

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F 761	Continued From page 106 #2. LPN #2 unlocked the medication refrigerator. The following was observed inside the medication refrigerator: - Two bottles of lorazepam intensol (1) solution inside of a separately locked compartment that was unlocked. - Three bottles of lorazepam intelsol solution on a shelf on top of the separately locked compartment. - The separately locked compartment was attached/under the refrigerator shelf that could be completely removed from the refrigerator. Other medications such as insulin were also stored in the refrigerator. On 10/23/19 at 11:03 a.m., an interview was conducted with LPN #2. LPN #2 was asked how lorazepam intensol should be stored. LPN #2 stated, "In a locked box in a locked refrigerator." When asked if someone should be able to remove the locked box from the refrigerator, LPN #2 stated, "No." LPN #2 confirmed all of the above observations. The facility/pharmacy policy titled, "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" documented, "12.2 After receiving controlled substances and adding to inventory, Facility should ensure that Schedule II-V controlled substances are immediately placed into a secured storage area (i.e., a safe, self-locked cabinet, or locked room, in all cases in accordance with Applicable Law)." On 10/23/19 at 4:25 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.	F 761	potential to be affected by deficient practice. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? Executive Director and Maintenance Director ordered larger, locked medication storage compartments for medication room refrigerators. By 11/25/2019, new boxes will be secured in refrigerators. -By 11/25/2019, Staff Development Coordinator or Designee will re-educate licensed nurses on facility policy "Storage and Expiration of Medications". Any licensed nurse that has not completed re-education by 11/25/2019, will not be allowed to work until education is completed. All newly hired staff will receive education during orientation on facility policy "Storage and Expiration of Medications". -Director of Nursing or Designee will validate locked boxes within medication room refrigerators for securement weekly x90 days. 4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccurring? -Director of Nursing will present findings of audit to the Quality Assurance Performance Improvement committee for	

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F 761	Continued From page 107 No further information was provided prior to exit. (1) Lorazepam is a prescription medicine used: To treat anxiety disorders. Lorazepam is a federal controlled substance (C-IV) because it can be abused or lead to dependence. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=5ff82103-cc57-4af9-9362-82a7c686271d	F 761	review and recommendations for 90 days. QAPI committee consists of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Manager, Pharmacy Consultant, and Medical Director.	
F 812 SS=D	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 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	F 812	1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	11/29/19

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F 812	Continued From page 108 opened date on dry goods in the kitchen and discard thickened tea past its use by date in the stand-up refrigerator. The findings include: On 10/22/19 at approximately 12:30 p.m., an observation of the facility's kitchen was conducted with OSM (other staff member) #7, the dietary manager. Observation of the dry food storage area revealed an opened 16-ounce bag of miniature marshmallows approximately one-half full. Observation of the bag failed to evidence an opened or use by date. OSM #7 stated that the bag should have been dated when opened. OSM #7 removed the bag from the dry storage area. Further observation of the kitchen area revealed a double door stand up refrigerator, which contained a 46-ounce carton, labeled "honey like consistency thickened sweetened tea". Further observation of the carton revealed a date of 7/3/19 written in black marker and a yellow stick-on note attached to the carton with "UB [use by] 10-3-19." When asked what the dates meant, OSM #7 stated that 7/3/19 was the date the carton was received at the facility and that 10-3-19 was the date that the carton should be used by. When asked if the carton should be in the stand-up refrigerator, OSM #7 stated, "No." When asked if it was available for use, OSM #7 stated, "Yes, but she did not think that there were any residents who drink that anymore." OSM #7 stated that is should have been removed from the refrigerator on 10-3-19. On 10/22/19 at 1:00 p.m., an interview was conducted with OSM #7. When asked about the process for opened dry goods, OSM #7 stated	F 812	Marshmallow's and thickened liquids without opened dates or use by dates were discarded while surveyor's were still on-site. No resident was found to be affected by deficient practice. 2. How will the facility identify other residents having the potential to be affected by the same practice? -All residents living within the facility have potential to be affected by deficient practice. *On 10/22/2019, Dietary Manager completed 100% assessment of all dry foods and thickened liquids to validate use by dates and open date labels for accuracy and within date. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? By 11/15/2019, Dietary Manager will re-educate kitchen staff on facility policy "Food in Storage Areas". Any dietary staff that has not completed re-education by 11/25/2019, will not be allowed to work until education is completed. All newly hired dietary staff will receive education during orientation on facility policy "Food in Storage Areas". -Dietary Manager or Designee will audit thickened liquids for use by date and 5 random dry foods for use by date 5x/week x30 days, 3x/week x30 days, and 1x/week x 30 days.	

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F 812	Continued From page 109 that items are dated when opened. When asked about the one-half full, 16-ounce bag of mini marshmallows observed in the kitchen dry storage area, OSM #7 stated, "They should have had a date." When asked the process staff follows for opened refrigerated items, OSM #7 stated that they are dated when opened and discarded when they reach the use by date. OSM #7 stated that the thickened sweetened tea found in the stand-up refrigerator had not been used because there were not any residents that drink it at the facility currently. The facility policy "Food in Storage Areas" documented in part, "Dry storage; Be sure to label and date the container. Folding the top down, taping, or wrapping the item in plastic wrap is not sufficient." The policy failed to document guidance on discarding refrigerated items past their use by date. According to ServSafe Manager, 7th edition, 2017, page 5.16 documented "If you find expired, damaged, spoiled, or incorrectly stored food that has become unsafe, you should discard it. This includes food that is missing a date mark, ready-to-eat TCS (time/temperature control for safety) food that has exceeded its date mark, and food that has exceeded time/temperature requirements." On 10/24/19 at approximately 12:15 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit.	F 812	4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccurring? -Dietary Manager will present findings of audit to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. QAPI committee consists of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Manager, Pharmacy Consultant, and Medical Director.	
F 842	Resident Records - Identifiable Information	F 842		11/29/19

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F 842 SS=D	Continued From page 110 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842		

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F 842	Continued From page 111 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to maintain an accurate clinical record for two of 47 residents in the survey sample, Residents #67 and #12. Resident #67's Level 1 (initial) PASRR (Preadmission Screening and Resident Review) screening was coded incorrectly at the time of Resident #67's admission on 6/11/19. The facility staff failed to ensure that Resident #12's clinical	F 842	1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? -Resident #67 PASRR was corrected while surveyor still on site. -Resident #12 medical record was audited by HIM Director to ensure accurate information for resident only in medical	

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F 842	Continued From page 112 record did not contain documents that belonged to another resident. The findings include: 1. Resident #67 was admitted to the facility on 6/11/19; diagnoses include, but are not limited to, Parkinson's disease (1) and schizophrenia (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 9/20/19, Resident #67 was coded as being mildly cognitively impaired for making daily decisions, having scored 13 out of 15 on the BIMS (brief interview for mental status). On the admission MDS, with an assessment reference date of 6/20/19, in Section A1500, Resident #20 was coded as not having been evaluated by a Level 2 PASRR (Preadmission Screening and Resident Review), and determined to have a serious mental illness and/or mental retardation or a related condition. A review of Resident #20's clinical record revealed a document, "Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions." A review of this document revealed, in part, the following: "5. RECOMMENDATION: a. Refer for secondary assessment...MI (mental illness)." The "a." was circled. Further review of the clinical record revealed no evidence of a secondary assessment for Resident #20. On 10/23/19 at 11:11 a.m., OSM (other staff member) # 3, the social services director, was interviewed. When asked why the secondary mental health assessment had not been done for	F 842	record. 2. How will the facility identify other residents having the potential to be affected by the same practice? -All residents living within the facility have potential to be affected by deficient practice. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? -By 11/15/2019, Social Services will be educated on Pre-admission Screening policy. -By 11/15/2019, Social Services will audit all residents PASRR level 1 to ensure accuracy of information. -Social Services will audit all admission PASRR level 1 screenings for accuracy x90 days in order to maintain an accurate medical record. -By 11/25/2019, all staff will be educated on maintaining an accurate medical record including appropriate filing of progress notes within correct medical record. -By 11/19/2019, HIM director will audit all medical records for accurate progress note placement in correct medical record. -HIM Director or Designee will audit 5	

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F 842	Continued From page 113	F 842		

Resident #20, OSM #3 stated, "Sometimes it can take a few months to get them done." When asked the purpose of a secondary/level 2 assessment for a resident, OSM #3 stated, "I am really new to this job. I've only been here a few months. I'm not really sure, to tell you the truth. Let me get back to you and let you know." On 10/23/19 at 3:30 p.m., OSM #3 returned and stated, "I have done some checking. The Level 1 (initial) screening was coded incorrectly. This resident should never have been marked as needing any follow-up. She doesn't need screening for additional services. She does not qualify. It is a mistake in the document."

On 10/24/19 at 11:00 a.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy, "Pre-admission Screening," revealed, in part, the following: "Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care."

No further information was provided prior to exit.

(1) "Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families." This information is taken from the website https://medlineplus.gov/parkinsonsdisease.html.

(2) "Schizophrenia is a serious brain illness.

medical records for accuracy of resident documents per unit (15 total) 1 time per week x90 days.

4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccurring?

-Director of Nursing will present findings of audit to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. QAPI committee consists of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Manager, Pharmacy Consultant, and Medical Director.

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F 842	Continued From page 114	F 842		

People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves." This information is taken from the website https://medlineplus.gov/schizophrenia.html

2. The facility staff failed to ensure that Resident #12's clinical record did not contain documents that belonged to another resident.

Resident #12 was admitted on 12/2/14, diagnoses include but are not limited to, high blood pressure, heart disease, edema, atrial fibrillation, congestive heart failure, and diabetes. The annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/11/19 coded the resident as being severely impaired in ability to make daily life decisions, scoring a 3 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.

A review of the clinical record revealed a physician's progress note that belonged to another resident.

On 10/24/19 at 9:22 AM, an interview was conducted with OSM (other staff member) #5, Medical Records. When asked about the process for filing in the charts, OSM #5 stated, "We go through them, file and remove items to be thinned out. OSM #5 stated, "We have folders for each unit with room numbers, we file the paperwork in there and then file them in the charts. Whenever we go to thin the records we try to check to see if stuff is misplaced or the wrong stuff is in there." When asked how frequently this process is completed, OSM #5 stated, "For new admission

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F 842	Continued From page 115 people we check in 72 hours and in 15 days. For long-term care people we just do it whenever we think it needs to be thinned. There is no time schedule on it." When asked if another resident's paperwork should be on Resident #12's chart, OSM #5 stated, "No. Because it wasn't for that resident." When asked if there was any potential outcome for having another resident's paperwork on the wrong chart, OSM #5 stated, "It could be if that person went out and it got sent to an appointment or hospital and someone else could have got that information." On 10/24/19 at 12:16 AM, ASM #1 (Administrative Staff Member) the Executive Director, and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		11/29/19

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F 880	Continued From page 116	F 880		

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 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.

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F 880	Continued From page 117 §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 resident interview, staff interview, clinical record review and facility document review, it was determined that facility staff failed to implement infection control practices for the care of an indwelling catheter for two of 47 residents in the survey sample, Residents # 49 and # 23. The facility staff failed to maintain Resident # 49 catheter tubing off the floor to prevent possible infection while he was sitting in his wheelchair. The findings include: 1. Resident # 49 was admitted to the facility on 04/09/2019 with diagnoses that included but were not limited to Parkinson's disease [1], obstructive and reflux uropathy [2] and anxiety [3]. Resident # 49's most recent MDS (minimum data set), an quarterly assessment with an ARD (assessment reference date) of 09/06/19, coded Resident # 49 as scoring a four on the brief interview for mental status (BIMS) of a score of 0 - 15, four - being severely impaired of cognition for making daily decisions. Resident # 49 was coded as requiring extensive assistance of one staff member for all activities of daily living. Section H "Bladder and Bowel" coded Resident #	F 880	1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? -On 11/11/2019, resident #49 was assessed for use of a leg bag for urine drainage from indwelling foley catheter while up in wheelchair. Staff will encourage leg bag while up in wheelchair as tolerated. -On 10/24/2019, resident #23 was given a storage bag for placement of incentive spirometer and education provided for storage. 2. How will the facility identify other residents having the potential to be affected by the same practice? *By 11/15/2019, Director of Nursing or designee will review all residents with indwelling foley catheters and assess for leg bag usage versus larger drainage bag while up in wheelchair. *By 11/15/2019, Director of Nursing or Designee will review all residents with	

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F 880	Continued From page 118 50 as having an indwelling catheter [2]. On 10/22/19 at 1:57 p.m., Resident # 49 was observed in his wheelchair engaged in an "Ice Cream Social" in the facility's activity room. Observation of Resident # 49's catheter collection bag revealed it was hanging under the wheelchair in a privacy bag. Observation of the catheter tubing reveal it was resting directly on the floor under the wheelchair. Further observation revealed Resident # 49's right foot resting on the tubing, putting the tubing between the bottom of his foot and the floor. On 10/22/19 at 2:25 p.m., Resident # 49 observed being pushed down the hallway in his wheelchair. Observation of the wheelchair revealed the catheter collection bag was hanging under the wheelchair in a privacy bag. Observation of the catheter tubing reveal it was rubbing on the floor under the wheelchair as Resident # 49 was being pushed down the hall in his wheelchair. On 10/23/19 at 4:10 p.m., Resident # 49 was observed sitting in his wheelchair in the hallway in front of the nurse's station. Observation of Resident # 49's catheter collection bag revealed it was hanging under the wheelchair in a privacy bag. Observation of the catheter tubing reveal it was resting on the floor under the wheelchair. Further observation revealed Resident # 49's right foot resting on the tubing, putting the tubing between the bottom of his foot and the floor. The POS [physician's order sheet] for Resident # 39 dated OCT [October] 2019" documented, "Catheter Care every shift and p.m. every shift for PREVENTION. Date Ordered: 06/19/2019."	F 880	incentive spirometers and ensure cleaning and storage protocol is in place. 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur? -By 11/25/2019, Staff Development Coordinator or Designee will educate licensed nurses on infection control practices, including foley catheters and incentive spirometers. Any licensed nurse that has not completed education by 11/25/2019, will not be allowed to work until education is completed. All newly hired staff will receive education during orientation on infection control practices including foley catheters and incentive spirometers. -Director of Nursing or Designee will review all resident's with foley catheters for leg bag usage or ensure tubing not on the floor while up in wheelchair 5x/week x30 days, 3x/week x30 days, and 1x/week x30 days. -Director of Nursing or Designee will review 5 resident's with incentive spirometer's for proper cleaning and storage 5x/week x30 days, 3x/week x30 days, and 1x/week x30 days. 4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccurring? -Director of Nursing will present findings of audit to the Quality Assurance Performance Improvement committee for	

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F 880	Continued From page 119 The comprehensive care plan for Resident # 49 dated 06/08/2019 documented, "Focus. Resident has an indwelling catheter: Urinary retention r/t [related to] obstructive uropathy. Date Initiated: 06/08/2019." On 10/24/19 at 8:40 a.m., an interview was conducted with CNA [certified nursing assistant] # 1. When asked to describe how a resident's catheter collection bag and catheter tubing should be positioned when a resident is in a wheelchair CNA # 1 stated, "The bag should be in a privacy bag and the tubing and the bag should not be touching the floor." When asked why it should not be touching the floor CNA # 1 stated, "To prevent infection." When asked who was responsible for ensuring the catheter bag and tubing are not in contact with the floor CNA # 1 stated, "Any nursing staff." When asked how often the position of the catheter bag and tubing are checked, CNA # 1 stated, "Every two hours and as needed." On 10/24/19 at 8:45 a.m., an interview was conducted with CNA # 2. When asked to describe how a resident's catheter collection bag and catheter tubing should be positioned when a resident is in a wheelchair, CNA # 2 stated, "The bag should be in a privacy bag and the tubing and the bag should not be touching the floor." When asked why it should not be touching the floor, CNA # 2 stated, "To prevent infection." On 10/24/19 at 8:50 a.m., an interview was conducted with LPN [licensed practical nurse # 1. When asked to describe how a resident's catheter collection bag and catheter tubing should be positioned when a resident is in a wheelchair,	F 880	review and recommendations for 90 days. QAPI committee consists of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Manager, Pharmacy Consultant, and Medical Director..	

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LPN # 1 stated, "The bag should be in a privacy bag and the tubing and the bag should not be touching the floor." When asked why it should not be touching the floor, LPN # 1 stated, "To prevent it from leaking, or tearing and for infection." When asked who was responsible for ensuring the catheter bag and tubing are not in contact with the floor, LPN # 1 stated, "Any nursing staff." When asked how often the position of the catheter bag and tubing are checked, LPN # 1 stated, "Every two hours and as needed."

On 10/24/19 at 12:10 p.m. ASM [administrative staff member] # 1, executive director and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

[2] A condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm.

[3] Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

2. The facility staff failed to implement infection control practices for storage of the incentive

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spirometer (1) Resident #23.

Resident #23 was admitted to the facility on 4/26/2019 with a readmission on 10/18/2019, with diagnoses that included but were not limited to sepsis (2), and orthopedic (3) aftercare. Resident #23's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/03/19, coded Resident #23 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions.

On 10/22/19 at approximately 2:30 p.m., an observation was made of Resident #23's room. Resident #23 was observed to be sitting beside the bed in a wheelchair, with the bedside table in front of her. An uncovered incentive spirometer was observed on the bedside table in front of Resident #23. The incentive spirometer was located between a foam cup with a lid and straw and a box of tissues. At this time, an interview was conducted with Resident #23. When asked about the incentive spirometer on the table Resident #23 stated that it was given to her when she was at the hospital the prior week following hip surgery. When asked if had used it recently Resident #23 stated she had used it this morning and she tries to do it five or six times a day. When asked if the staff know that she is using the incentive spirometer Resident #23 stated, "Yes." When asked how the incentive spirometer is stored Resident #23 stated that it stays on the bedside table. When asked if it is ever covered Resident #23 stated, "No."

Additional observations on 10/22/19 at 4:15 p.m., 10/23/19 at 9:00 a.m., and 10/24/19 at 9:15 a.m. revealed the incentive spirometer uncovered on

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the bedside table in Resident #23's room.

The document "Discharge Summary; After Visit Summary" dated 10/18/2019 for Resident #23 documented "Additional instructions as follows: Use Incentive Spirometer every hour while awake ..."

On 10/23/19 at 4:25 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked how incentive spirometers are stored LPN #3 stated that she was not sure. When asked if an incentive spirometer should be covered, LPN #3 stated that they have never been covered in the years that she has worked at the facility. LPN #3 stated that CPAP (continuous positive airway pressure) masks and nebulizer (handheld mouthpiece for medication delivery) are stored covered. LPN #3 stated that incentive spirometers could possibly be stored like these items as well. When asked why the CPAP masks and nebulizers are covered LPN #3 stated for infection control purposes.

On 10/23/19 at 4:35 p.m., an interview was conducted with RN (registered nurse) #5. When asked the process for storage of incentive spirometers RN #5 stated that they are uncovered and have never covered them in the past. RN #5 stated that staff have never been told that they should but she would consider it if it was something that needed to be done. When asked the process for storage of other respiratory items that reach the residents mouth RN #5 stated that they are stored covered. When asked why RN #5 stated to keep them clean. When asked about the incentive spirometer for Resident #23, RN #5 stated that it was brought back from the hospital last Tuesday when the resident had a

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surgery performed. When asked if Resident #23 uses the incentive spirometry RN #5 stated, "Yes, she does."

On 10/24/19 at 11:20 a.m., an interview was conducted with RN (registered nurse) #3, the assistant director of nursing. When asked what the purpose of an incentive spirometer, RN #3 stated that it is a piece of equipment used after surgery to expand the lungs and prevent atelectasis (lung collapse). When asked how it should be stored, RN #3 stated that she was not sure. When asked if an incentive spirometer reaches the resident's mouth, RN #3 stated, "Yes." When asked if respiratory equipment that reaches a resident's mouth should be kept clean, RN #3 stated yes and that infection control measures should be in place to keep it clean and it should be kept covered. When asked about the incentive spirometer for Resident #23, RN #3 stated that she was not aware the resident had one or was using it until today but other staff were aware. When asked what standard of practice is used at the facility RN #3 stated that they use their policies and Lippincott.

On 10/24/19 at approximately 8:30 a.m., a request was made to ASM (administrative staff member) #2, the director of nursing for the facility policy on incentive spirometry use and storage.

On 10/24/19 at approximately 12:00 p.m., the facility's policy "Oxygen Therapy- Mask & Nasal Cannula" was provided. The policy failed to evidence guidance on the storage of incentive spirometers.

According to Lippincott's Nursing Procedures seventh edition, page 384 documented, "Wash

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the mouthpiece in warm water and dry it. Avoid immersing the spirometer itself in water because water enhances bacterial growth and impairs the internal filter's effectiveness in preventing inhalation of extraneous material. Place the mouthpiece in a plastic storage bag between exercises, and label it and the spirometer, if applicable, with the patient's name to avoid inadvertent use by another patient. Keep the incentive spirometer within the patient's reach."

On 10/24/19 at approximately 12:15 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. Incentive spirometer
An incentive spirometer is a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm

2. Sepsis
An illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm.

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F 880	Continued From page 125 3. Orthopedic Orthopedics, or orthopedic services, aim at the treatment of the musculoskeletal system. This includes your bones, joints, ligaments, tendons, and muscles. This information was obtained from the website: https://medlineplus.gov/ency/article/007455.htm	F 880		