SKYLINE TERRACE NURSING HOME

P.O. Box 558
Telephone: (540) 459-3738 Woodstock, Virginia 22664 Fax: (540) 459-8651

October 22, 2018

Wietske Weigel-Delano
Department of Health
9960 Mayland Drive, Suite 401
Henrico,VA 23233-1485

Dear Ms. Delano,

Attached you will find the Skyline Terrace Nursing Home's Plan of Correction for Licensure survey ending on 10/4/2018. If you have any questions, please do not hesitate to contact me.

Sincerely,

Deanne L. Craft
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E075	A. BUILDING _____ B. WING _____	10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE TERRACE CONV HOME	PO BOX 558 WOODSTOCK, VA 22664

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/2/18 through 10/4/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaint(s) was/were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/2/18 through 10/4/18. 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 70 certified bed facility was 68 at the time of the survey. The survey sample consisted of 23 current resident reviews (Residents #20, #61, #53, #55, #269, #18, #64, #67, #40, #58, #36, #34, #35, #4, #23, #15, #41, #24, #25, #5, #8, #13, and #60) and 1 closed record review (Resident #71).	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deanne A. Craft	Administrator	10/22/18

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

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to maintain a resident's dignity for one of 24 residents in the survey sample, Resident # 53. The facility staff failed to provide privacy for Resident # 53's catheter collection bag.	F 550	**F550** **1. How will corrective action be accomplished for those residents found to be affected by the deficient practice?** A privacy bag is being utilized on Resident #53's catheter bag. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** DON and/or designee will audit residents with indwelling catheter collection bags to ensure that privacy bags are being used appropriately.	10/4/2018 10/4/2018

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F 550	Continued From page 2 The findings include: Resident # 53 was admitted to the facility on 11/07/17 with diagnoses that included but were not limited to: benign prostatic hyperplasia (1), gout (2), hemiplegia (3) and hypertension (4). Resident # 53's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 09/09/18, coded Resident # 53 as scoring a 7 (seven) on the brief interview for mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely impaired of cognition for making daily decisions. Resident # 53 was coded as requiring extensive to requiring total assistance of one staff member for activities of daily living. Section H "Bladder and Bowel" coded Resident # 53 as having an indwelling catheter. On 10/02/18 at approximately 1:18 p.m., an observation was conducted of Resident # 53 and Resident 53's catheter collection bag. Resident # 53 was in the A-side bed, next to the entrance of the room, lying in bed. Resident #53's catheter collection bag was observed hanging off the side of bed, on the entrance side of the room. The catheter bag was hanging outside of the privacy bag. Resident # 53's catheter collection bag could be seen from hallway. On 10/03/18 at approximately 3:10 p.m., an observation was conducted of Resident # 53 and Resident 53's catheter collection bag. Resident # 53 was in the A-side bed, next to the entrance of the room, lying in bed. Resident #53's catheter collection bag was observed hanging off the side of bed, on the entrance side of the room. The catheter bag was hanging outside of the privacy	F 550	**3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?** DON and/or designee will provide education to nursing staff to ensure that catheter collection bags are stored appropriately inside privacy bag.	10/25/2018

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F 550	Continued From page 3 bag. Resident # 53's catheter collection bag could be seen from hallway. Based on the MDS coding of Resident # 53 being severely impaired of cognition, Resident 53's could not be interviewed regarding the observations of the catheter collection bag not being placed in a privacy bag to respect his dignity. The comprehensive care plan for Resident # 53 with a revision date of 06/21/2018 documented, Focus: (Resident# 53) has indwelling Foley catheter. 16 FR (French) with 10 ml (milliliter balloon r/t (related to) urinary retention." Under "Interventions it documented, "CATHETER: (Resident # 53) has a 16 FR (French) Foley catheter. Position catheter bag and tubing below the level of the bladder and away from the entrance room door. Cover with privacy bag as indicated." On 10/03/18 03:20 p.m., an interview was conducted with CNA (certified nursing assistant) # 1 who had just come out of Resident # 53's room. When asked about the placement of a resident's catheter collection bag, CNA # 1 stated, "The bag is always in a cover, below the resident and off the floor and positioned so that it can't be seen from the hallway." CNA # 1 was asked to observe Resident # 53 from the hallway. When asked what she could see, CNA # 1 stated, "I see the collection bag and the tubing." CNA # 1 further stated, "It needs to be fixed." During the interview at approximately 3:24 p.m., LPN (licensed practical nurse) # 2 was observed entering Resident # 53's room and closing the door.	F 550	**4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?** DON and/or Designee will monitor catheter privacy bags to ensure catheter collection bags are stored appropriately inside privacy bags weekly x3 weeks. DON will report results to the QA committee. Findings and results will be reflected in the QA minutes.	11/16/2018 11/16/2018

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F 550	Continued From page 4 On 10/03/18 3:28 p.m., an interview was conducted with LPN (licensed practical nurse) # 2. When asked where Resident # 53's catheter collection bag and tubing was located, LPN # 2 stated, 'In front of the door." When asked why she entered Resident # 53's room at 3:24 p.m., LPN # 2 stated, "I saw the catheter bag was not in the privacy bag completely and I replaced so it was out of sight." When asked about the placement of a resident's catheter collection bag, LPN # 2 stated, "The bag should in a privacy so it can't be seen." The facility's policy "Catheter Care" documented, "Catheter bedside drainage bag should be placed in a privacy bag for Resident's dignity." The facility's "Resident's Rights" documented, "The resident has the right to be treated with respect and dignity, including: The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents." On 10/03/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.	F 550		

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F 550	Continued From page 5 (2) A type of arthritis. It occurs when uric acid builds up in blood and causes inflammation in the joints This information was obtained from the website: https://medlineplus.gov/ency/article/000422.htm. (3) 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. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 550	**F558** **1. How will corrective action be accomplished for those residents found to be affected by the deficient practice?** Resident #15's call bell was placed within reach.	10/3/2018
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. 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 provide accommodation of resident needs for one of 24 residents in the survey sample, Resident # 15.	F 558	**2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** DON and/or Designee will conduct a facility audit to ensure call bells are within each Resident's reach.	10/04/2018

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F 558	Continued From page 6 The facility staff failed to ensure Resident #15's call bell (a device with a button that can be pushed to alert staff when assistance is needed), was within the resident's reach. The findings include: Resident # 15 was admitted to the facility on 09/22/17 with diagnoses that included but were not limited to: aphasia (1), dysphagia (2), cerebral infarction (3) and hypertension (4). Resident # 15's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 08/06/18, coded Resident # 15 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. Resident # 15 was coded as totally dependent with the assistance of one staff member for activities of daily living. On 10/02/18 at 1:27 p.m., Resident # 15 was observed. He was in his bed, appeared neat and clean, nonverbal with decreased ROM (range of motion) of his RUE (right upper extremity). Observation of the call bell revealed it was attached to the upper left corner of the fitted sheet covering the mattress above Resident # 15's head. When Resident # 15 was asked to reach for and activate the call bell, he was unable to locate it. On 10/03/18 at 2:04 p.m., Resident # 15 was in his room reclined in a Gerri chair sitting next to his bed. Observation of Resident # 15's bed revealed the call bell was lying in the middle of	F 558	**3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?** DON and/or designee will provide staff education to ensure that call bells are accessible to residents. **4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?** DON and/or Designee will monitor resident call bell placement weekly x3 weeks to ensure continued compliance. DON will report results to the QA committee. Findings and results will be reflected in the QA minutes.	10/25/2018 11/16/2018 11/16/2018

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F 558	Continued From page 7 the bed. When Resident # 15 was asked to reach for and activate the call bell, he was unable to locate it. The comprehensive care plan for Resident # 15 dated 09/22/2017 documented, "Focus. (Resident # 15) has an ADL (activities of daily living) self-care performance deficit r/t (related to) right sided hemiparesis age, immobility and contracture of right hand." Under "Interventions" it documented, "Encourage the resident to use bell to call for assistance. Date initiated: 09/22/2017." On 10/03/18 at 2:11 p.m., an interview was conducted with CNA (certified nursing assistant) # 2 and # 3. When asked about the placement of a resident's call bell, CNAs # 2 and # 3 stated, "It should be within resident's reach." CNAs # 2 and # 3 were then asked to observe Resident # 15 and the placement of his call bell. They acknowledged Resident # 15 was in a Gerri chair next to his bed and the call bell was in the middle of Resident # 15's bed and that it was not within reach of Resident # 15. When asked if they had brought Resident # 15 back to his room from having lunch." CNAs # 2 and # 3 stated no. On 10/03/18 at 2:17 p.m., an interview was conducted with CNA # 4. When asked about the placement of a resident's call bell, CNA #4 stated, "Make sure the call bell is within his reach." After observing, the position of Resident # 15's call bell CNA # 4 was asked if Resident # 15 could reach the call bell. CNA # 4 stated, "No." When asked if she brought Resident # 15 back into his room following lunch, CNA # 4 stated, "When I brought him in the room I put him next to the bed and moved the call bell over on the bed and put his	F 558		

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F 558	Continued From page 8	F 558		

hand on it to make sure he could reach it. I have no idea how it was moved." When asked if Resident # 15 had the ability to move the call bell to the middle of the bed from his position, CNA # 4 stated, "No."

The facility's policy "Call Bell Utilization" documented, "Call bells should be accessible to residents when they are in the room and / or bathroom."

The facility's "Resident's Rights" documented, "The resident has the right to be treated with respect and dignity, including: The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents."

On 10/03/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) 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

(2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdi

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F 558	Continued From page 9 sorders.html. (3) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm . (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 558		
F 622 SS=E	Transfer and Discharge Requirements 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.	F 622	**F622** **1. How will corrective action be accomplished for those residents found to be affected by the deficient practice?** The following items will be forwarded to Shenandoah Memorial Medical Records department for Residents #20, #24, #5, #40, and #64: A. Contact information of the practitioner responsible for the care of the Resident. B. Resident representative information including contact information.	11/16/2018

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F 622	Continued From page 10 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 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	F 622	C. Advance Directive information. D. Special instructions or precautions for ongoing care. E. Care Plan Goals. F. All other necessary information including a discharge summary. Information forwarded to the Hospital will be documented in the Resident's facility medical record.	11/16/2018

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F 622	Continued From page 11 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 (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, clinical record review and facility document review, it was determined that the facility staff failed to evidence that all required documentation was provided to the receiving facility for 5 of 37 residents in the survey sample; Residents #20, #24, #5, #40, and #64. 1. The facility staff failed to evidence that all required documentation was sent to the hospital upon Resident #20's facility initiated transfer to the hospital on 7/26/18. 2. The facility staff failed to evidence that all	F 622	**2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** Facility will audit Resident's that were discharged/transferred within the last 30 days to ensure that the transfer documentation has been forwarded to the receiving facility and appropriately documented in the Resident's facility medical record.	11/16/2018

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F 622	Continued From page 12 required documentation was sent to the hospital upon Resident #24's facility initiated transfer to the hospital on 7/31/18. 3. The facility staff failed to evidence that all required documentation was sent to the hospital upon Resident #5's facility initiated transfer to the hospital on 7/1/18. 4. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident #40 was transferred to the hospital on 8/16/18, 8/18/18, 8/27/18 and 9/7/18. 5. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 07/08/18 for Resident # 64. The findings include: 1. The facility staff failed to evidence that all required documentation was sent to the hospital upon Resident #20's facility initiated transfer to the hospital on 7/26/18. Resident #20 was admitted to the facility on 5/8/18 with the diagnoses of but not limited to hypothyroidism, osteoarthritis, high blood pressure, macular degeneration, heart disease, dysphagia, and chronic respiratory failure. The most recent MDS (Minimum Data Set) was a	F 622	**3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?** DON and/or Designee has created a transfer/discharge form to include: 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. Special instructions or precautions for ongoing care. E. Care Plan Goals.	11/16/2018

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F 622	Continued From page 13 quarterly assessment with an ARD (Assessment Reference Date) of 8/13/18. The resident was coded as being moderately impaired in ability to make daily life decisions. A review of the clinical record revealed a "Transfer/Discharge Policy" form dated 7/26/18 and signed by the physician on 8/1/18 that documented the following: What specific resident needs are not able to be met by (facility)? Shortness of breath, BP 132/90, c/o "rocks on chest" abnormal lung sounds and need to rule out myocardial infarction. What efforts were offered at (facility) to meet the resident's needs? Oxygen, meds per orders, assess s/s. What services will be offered by receiving facility to better meet the resident's needs? Acute diagnostics for chest pain and abnormal vitals. A review of the clinical record revealed nurses notes dated 7/26/18 at 2:47 a.m., that documented, "Resident complaint {sic} of shortness of Breath {sic}, 98.7 (temperature) 44 (respirations) 132/90 (blood pressure) HR (heart rate) 92-104 90-92% (oxygen saturation) on 2 liters of oxygen. Resident states it feels "like a rock on my chest." Resident's lungs sounds rhonchi, wheezing, audible wheezing. This writer spoke with MD (medical doctor) and was direct {sic} to send resident to (hospital) for eval (evaluation). This writer contacted 911 and (hospital) ED (emergency department). This writer notify {sic} POA (power of attorney). will {sic} continue to monitor."	F 622	F. All other necessary information including a discharge summary. The transfer/discharge form will be sent to the receiving facility and maintained within the Resident's facility medical record. DON and/or designee will educated all licensed nurses on the discharge/transfer process.	11/16/2018 11/16/2018

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F 622	Continued From page 14 A nurses note dated 7/26/18 at 3:03 a.m., documented, "resident is at (hospital) ICU (intensive care unit) will continue to monitor." Further review of the clinical record failed to reveal any evidence of what documentation, if any, was sent to the hospital. On 10/3/18 at 1:18 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. RN #1 stated the nurses send a copy of the residents' MAR (medication administration record), TAR (treatment administration record) and a face sheet. When asked if nurses provide residents' comprehensive care plan goals, RN #1 stated, "They don't normally go." When asked how nurses evidence the information provided to hospital staff, RN #1 stated nurses usually document the information provided in a nurse's note. On 10/3/18 at 1:59 p.m., ASM (administrative staff member) #2 (the director of nursing) presented a blank form titled, "Transfer Discharge Record" (blank) that she stated is auto-populated by the system when they print it for hospital transfers. ASM #2 stated the nurses are supposed to fill the form out and send the form to the hospital each time a resident is transferred. The form documented sections to be completed regarding: resident information (demographics and insurance information), other information (allergies and advance directives), physician/representative contact information, diagnoses, last vital signs, chief complaint and "relevant information" regarding behavior(s), ambulation, bladder, bowel and feeding. The	F 622	**4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?** DON and/or designee will monitor discharges/transfers x3 weeks to ensure that all required documentation was provided to the receiving facility. DON will report results to the QA committee. Findings and results will be reflected in the QA minutes.	11/16/2018 11/16/2018

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F 622	Continued From page 15	F 622		

form failed to document a section for nurses to complete regarding comprehensive care plan goals. ASM #2 stated the form is supposed to be completed and sent to the hospital along with residents' MAR, TAR, advance directives, last progress notes and any relevant labs [laboratory tests]. ASM #2 stated the nurses also call a report to hospital staff. When asked how the facility staff could evidence all required information was provided to hospital staff when each resident was transferred, ASM #2 stated she could only provide this blank form. ASM #2 stated the nurses do not make a copy of the completed transfer discharge form to evidence they are completed.

A review of the facility policy "Transfer/Discharge Policy" documented, "Procedure: *When it is determined that a resident must be transferred or discharged, based on ensuring resident's care needs can be met, the facility will initiated transfer/discharge. *MD documentation supporting rationale for transfer/discharge will be maintained in the medical record. *Before a transfer or discharge, the facility staff will document: Reason for transfer; Appropriate notice to resident and or responsible person; Discharge plans and mode of transportation. *When a transfer or discharge is initiated, the facility staff will send documents including, but not limited to the following: Face sheet; Current EMAR/TAR [electronic medication administration record/treatment administration record]; Transfer/Discharge Form; Advanced Directives; Progress Notes; MD Orders; Pertinent Laboratory Results; Any other documentation required to ensure the continuity of care for the resident."

The policy did not include requirement for

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F 622	Continued From page 16 sending the comprehensive care plan goals and the facility could not evidence that any of the other required documentation listed in the policy was sent either. On 10/3/18 at 5:12 p.m., the ASM #1 and ASM #2 (Administrative Staff Members - the Administrator and Director of Nursing, respectively) 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 all required documentation was sent to the hospital upon Resident #24's facility initiated transfer to the hospital on 7/31/18. Resident #24 was admitted to the facility on 6/4/12 with the diagnoses of but not limited to diabetes, anxiety, high blood pressure, depression, cerebral palsy, and dementia. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 8/14/18. The resident was coded as being cognitively intact in ability to make daily life decisions. A review of the clinical record revealed a "Transfer/Discharge Policy" form dated 7/31/18 and signed by the physician on 8/31/18 that documented the following: What specific resident needs are not able to be met by (facility)? Worsening s/s (signs/symptoms) of aspiration, hypoxia, congestion. What efforts were offered at (facility) to meet the	F 622		

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F 622	Continued From page 17	F 622		

resident's needs? O2 (oxygen) applied, unable to raise O2 saturation.

What services will be offered by receiving facility to better meet the resident's needs? IV (intravenous) abx (antibiotic), diagnostic abilities r/t (related to) acute concerns, swallowing studies.

A review of the clinical record revealed nurses notes dated 7/26/18 at 2:30 PM that documented, "Resident left with Brother {sic} to have lunch at McDonalds {sic} brother reported that resident had no issues with her meal until she was drinking her milkshake. Brother stated that resident had a coughing episode while drinking her shake. Resident returned to facility with white milky substance and chunks of food on her shirt. VS (vital signs) Temp 98.2 BP (blood pressure) 108/60 P (pulse) 120 R (respirations) 20 and O2 (oxygen) is 76%. Resident started on 2L (liters) of oxygen. Vital signs to be monitored."

A nurses note dated 7/26/18 at 4:20 PM documented, "Resident has continued with audible congestion and gurgling with vocalizations. Voice sounds as if she is speaking underwater. Resident O2 saturation at 82% at this time. While speaking with resident, she moved her oxygen and states she isn't going to wear it. Spoke with the MD and new order obtained to send resident to the ED [emergency department] for evaluation and treatment."

A nurses note dated 7/26/18 at 4:40 p.m., documented, "Resident is sent out with EMT [Emergency medical technician] at 16:39 (4:39 PM) with 02 sat of 83% HR (heart rate) 139."

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F 622	Continued From page 18 A nurses note dated 7/26/18 at 8:21 p.m., documented, "Received a call from ER [emergency room] nurse that resident is been {sic} admitted to critical care (hospital) for aspiration pneumonia." Further review of the clinical record failed to reveal any evidence of what documentation, if any, was sent to the hospital. On 10/3/18 at 1:18 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. RN #1 stated the nurses send a copy of the residents' MAR (medication administration record), TAR (treatment administration record) and a face sheet. When asked if nurses provide residents' comprehensive care plan goals, RN #1 stated, "They don't normally go." When asked how nurses evidence the information provided to hospital staff, RN #1 stated nurses usually document the information provided in a nurse's note. On 10/3/18 at 1:59 p.m., ASM (administrative staff member) #2 (the director of nursing) presented a blank form titled, "Transfer Discharge Record" (blank) that she stated is auto-populated by the system when they print it for hospital transfers. ASM #2 stated the nurses are supposed to fill the form out and send the form to the hospital each time a resident is transferred. The form documented sections to be completed regarding: resident information (demographics and insurance information), other information (allergies and advance directives), physician/representative contact information, diagnoses, last vital signs, chief complaint and	F 622		

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F 622	Continued From page 19 "relevant information" regarding behavior(s), ambulation, bladder, bowel and feeding. The form failed to document a section for nurses to complete regarding comprehensive care plan goals. ASM #2 stated the form is supposed to be completed and sent to the hospital along with residents' MAR, TAR, advance directives, last progress notes and any relevant labs. ASM #2 stated the nurses also call a report to hospital staff. When asked how the facility staff could evidence all required information was provided to hospital staff when each resident was transferred, ASM #2 stated she could only provide this blank form. ASM #2 stated the nurses do not make a copy of the completed transfer discharge form to evidence they are completed. On 10/3/18 at 5:12 PM the ASM #1 and ASM #2 (Administrative Staff Members - the Administrator and Director of Nursing, respectively) 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 all required documentation was sent to the hospital upon Resident #5's facility initiated transfer to the hospital on 7/1/18. Resident #5 was admitted to the facility on 6/25/18 with the diagnoses of but not limited to epilepsy, cerebrovascular disease, stroke, kidney disease, Alzheimer's disease, neurogenic bladder, diabetes, dementia, and deep vein thrombosis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/13/18. The resident was coded as being severely	F 622		

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F 622	Continued From page 20 impaired in making daily life decisions. A review of the clinical record revealed a "Transfer/Discharge Policy" form dated 7/1/18 and signed by the physician on 8/1/18 that documented the following: What specific resident needs are not able to be met by (facility)? 20 min (minute) seizure, not able to obtain vitals. What efforts were offered at (facility) to meet the resident's needs? attempted vitals, obtained blood sugar. What services will be offered by receiving facility to better meet the resident's needs? stat meds, diagnostics, stabilization post seizure. A review of the clinical record revealed nurse's notes dated 7/1/18 at 1:29 AM that documented, "Temp (temperature) 97.7, Resp {sic} (Respirations) 18, BP (blood pressure) 122/62. Resident started with seizure and didn't obtain rest of vitals. M.D. (medical doctor) notified and gave order to send to ER (emergency room). POA (power of attorney) notified and will meet resident at ER. Squad here and transported at 0119 (1:19 AM) to (hospital). Seizure lasted approx. (approximately) 20 minutes. CNA (certified nursing assistant) stayed with resident during this time." Further review of the clinical record failed to reveal any evidence of what documentation, if any, was sent to the hospital. On 10/3/18 at 1:18 p.m., an interview was conducted with RN (registered nurse) #1. RN #1	F 622		

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F 622	Continued From page 21 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. RN #1 stated the nurses send a copy of the residents' MAR (medication administration record), TAR (treatment administration record) and a face sheet. When asked if nurses provide residents' comprehensive care plan goals, RN #1 stated, "They don't normally go." When asked how nurses evidence the information provided to hospital staff, RN #1 stated nurses usually document the information provided in a nurse's note. On 10/3/18 at 1:59 p.m., ASM (administrative staff member) #2 (the director of nursing) presented a blank form titled, "Transfer Discharge Record" (blank) that she stated is auto-populated by the system when they print it for hospital transfers. ASM #2 stated the nurses are supposed to fill the form out and send the form to the hospital each time a resident is transferred. The form documented sections to be completed regarding: resident information (demographics and insurance information), other information (allergies and advance directives), physician/representative contact information, diagnoses, last vital signs, chief complaint and "relevant information" regarding behavior(s), ambulation, bladder, bowel and feeding. The form failed to document a section for nurses to complete regarding comprehensive care plan goals. ASM #2 stated the form is supposed to be completed and sent to the hospital along with residents' MAR, TAR, advance directives, last progress notes and any relevant labs. ASM #2 stated the nurses also call a report to hospital staff. When asked how the facility staff could evidence all required information was provided to hospital staff when each resident was transferred,	F 622		

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F 622	Continued From page 22 ASM #2 stated she could only provide this blank form. ASM #2 stated the nurses do not make a copy of the completed transfer discharge form to evidence they are completed. On 10/3/18 at 5:12 PM the ASM #1 and ASM #2 (Administrative Staff Members - the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was provided by the end of the survey. 4. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident #40 was transferred to the hospital on 8/16/18, 8/18/18, 8/27/18 and 9/7/18. Resident #40 was admitted to the facility on 9/27/06. Resident #40's diagnoses included but were not limited to diabetes, urinary tract infection and obesity. Resident #40's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/12/18, coded the resident's cognition as being moderately impaired. Review of Resident #40's clinical record revealed the resident was transferred to the hospital on the following dates: -8/16/18 for an ankle evaluation after a fall. -8/18/18 for a change in condition involving the resident shaking and a change in vital signs. -8/27/18 for a non-responsive episode. -9/7/18 for a non-responsive episode.	F 622		

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Further, review of Resident #40's clinical record (including nurses' notes) for each transfer failed to reveal evidence that the facility staff provided the required information to hospital staff. The nurses' notes did not document what information was provided.

On 10/3/18 at 1:18 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. RN #1 stated the nurses send a copy of the residents' MAR (medication administration record), TAR (treatment administration record) and a face sheet (containing physician, contact information, representative contact information and advanced directives). When asked if nurses provide residents' comprehensive care plan goals, RN #1 stated, "They don't normally go." When asked how nurses evidence the information provided to hospital staff, RN #1 stated nurses usually document the information provided in a nurse's note.

On 10/3/18 at 1:59 p.m., ASM (administrative staff member) #2 (the director of nursing) presented a blank auto populated form titled, "Transfer Discharge Record (blank)." ASM #2 stated the nurses are supposed to fill the form out and send the form to the hospital each time a resident is transferred. The form documented sections to be completed regarding: resident information (demographics and insurance information), other information (allergies and advanced directives), physician/representative contact information, diagnoses, last vital signs, chief complaint and "relevant information" regarding behavior(s), ambulation, bladder, bowel and feeding. The form failed to document a

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(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 622	Continued From page 24	F 622		

section for nurses to complete regarding comprehensive care plan goals. ASM #2 stated the form is supposed to be completed and sent to the hospital along with residents' MAR, TAR, advanced directives, last progress notes and any relevant labs. ASM #2 stated the nurses also call a report to hospital staff. When asked how the facility staff could evidence all required information was provided to hospital staff when each resident was transferred, ASM #2 stated she could only provide this blank form. ASM #2 stated the nurses do not copy completed transfer discharge records to evidence they are completed.

On 10/3/18 at 5:07 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern.

No further information was presented prior to exit.

5. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 07/08/18 for Resident # 64.

Resident # 64 was admitted to the facility on 11/09/15 with diagnoses that included but were not limited to: dementia (1), depressive disorder (2), anxiety (3) and hypertension (4).

Resident # 64's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/21/18, coded Resident # 64 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being moderately impaired of cognition

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	49E075	A. BUILDING _____ B. WING _____	10/04/2018

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F 622	Continued From page 25 for making daily decisions. The nurse's "Progress Notes" for Resident # 64 documented, "07/08/18. 10:42 a.m., Resident is SOB (short of breath) and has non productive (sic.) cough, O@ (oxygen) sat (saturation) is 89 - 92% (percent) on 2L (two liters) @ via (by) n/c (nasal cannula). T (temperature) 98.0. P (pulse) 73. R (respiration) 14. And BP (blood pressure) 100/62 (one hundred over sixty-two). Spoke with (Name of Physician) via telephone and he would like her sent to ER (emergency room) for evaluation ..." At 11:10 a.m., the nurse's "Progress Notes" for Resident # 64 documented, "Sent to E.R. (emergency room) to eval (evaluate) and treat per (Name of Physician's) orders. POA (power of attorney (Name of POA) notified." Review of Resident # 64's clinical record and EHR (electronic health record) failed to evidence documentation that the facility provided physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals were provided to the hospital staff when Resident #64 was transferred to the hospital on 07/08/18. On 10/3/18 at 1:18 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. RN #1 stated the nurses send a copy of the residents' MAR (medication administration record), TAR (treatment administration record) and a face sheet. When asked if nurses provide residents' comprehensive care plan goals, RN #1 stated, "They don't normally go." When asked	F 622		

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F 622	Continued From page 26 how nurses evidence the information provided to hospital staff, RN #1 stated nurses usually document the information provided in a nurse's note. On 10/3/18 at 1:59 p.m., ASM (administrative staff member) #2 (the director of nursing) presented a blank auto populated form titled, "Transfer Discharge Record (blank)." ASM #2 stated the nurses are supposed to fill the form out and send the form to the hospital each time a resident is transferred. The form documented sections to be completed regarding: resident information (demographics and insurance information), other information (allergies and advance directives), physician/representative contact information, diagnoses, last vital signs, chief complaint and "relevant information" regarding behavior(s), ambulation, bladder, bowel and feeding. The form failed to document a section for nurses to complete regarding comprehensive care plan goals. ASM #2 stated the form is supposed to be completed and sent to the hospital along with residents' MAR, TAR, advance directives, last progress notes and any relevant labs. ASM #2 stated the nurses also call a report to hospital staff. When asked how the facility staff could evidence all required information was provided to hospital staff when each resident was transferred, ASM #2 stated she could only provide this blank form. ASM #2 stated the nurses do not copy completed transfer discharge records to evidence they are completed. On 10/093/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.	F 622		

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F 622	Continued From page 27 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) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 622		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		

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F 656	Continued From page 28 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 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to follow	F 656	**F656** **1. How will corrective action be accomplished for those residents found to be affected by the deficient practice?** A privacy bag is being utilized on Resident #53's catheter bag as stated in the Resident's care plan. Call bell was placed within reach for Resident #15 as stated in the Resident's care plan.	10/4/2018 10/3/2018

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F 656	Continued From page 29 the comprehensive care plan for two of 24 residents in the survey sample, Resident # 53 and # 15. 1. The facility staff failed to follow the comprehensive care plan for Resident # 53's catheter collection bag. 2. The facility staff failed to follow the comprehensive care plan for Resident # 15's call bell. The findings include: 1. The facility staff failed to follow the comprehensive care plan for Resident # 53's catheter collection bag. Resident # 53 was admitted to the facility on 11/07/17 with diagnoses that included but were not limited to: benign prostatic hyperplasia (1), gout (2), hemiplegia (3) and hypertension (4). Resident # 53's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 09/09/18, coded Resident # 53 as scoring a 7 (seven) on the brief interview for mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely impaired of cognition for making daily decisions. Resident # 53 was coded as requiring extensive to requiring total assistance of one staff member for activities of daily living. Section H "Bladder and Bowel" coded Resident # 53 as having an indwelling catheter. On 10/02/18 at approximately 1:18 p.m., and at approximately 5:55 p.m., observations were	F 656	**2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** DON and/or designee will audit residents with an indwelling catheter care plan to ensure that the catheter is being appropriately placed within the privacy bag. DON and/or designee will audit residents with a care plan to have call bell within reach to ensure care plan compliance.	10/4/2018 10/4/2018

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F 656	Continued From page 30 conducted of Resident # 53 and Resident 53's catheter collection bag. Resident # 53 was in the A-side bed, next to the entrance of the room, lying in bed. Resident #53's catheter collection bag was observed hanging off the side of bed, on the entrance side of the room. The catheter bag was hanging outside of the privacy bag. Resident # 53's catheter collection bag could be seen from hallway. On 10/03/18 at approximately 7:36 a.m., at approximately 11:36 a.m., observations were conducted of Resident # 53 and Resident 53's catheter collection bag. Resident # 53 was in the A-side bed, next to the entrance of the room, lying in bed and the catheter collection bag hanging off the side of bed in a privacy bag on the entrance side of the room, off the floor and it could be seen from hallway. On 10/03/18 at approximately 3:10 p.m., an observation was conducted of Resident # 53 and Resident 53's catheter collection bag. Resident # 53 was in the A-side bed, next to the entrance of the room, lying in bed. Resident #53's catheter collection bag was observed hanging off the side of bed, on the entrance side of the room. The catheter bag was hanging outside of the privacy bag. Resident # 53's catheter collection bag could be seen from hallway Based on the MDS coding of Resident # 53 being severely impaired of cognition, Resident 53's could not be interviewed regarding the observations of the catheter collection bag not being placed in a privacy bag to respect his dignity.	F 656	**3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?** DON and/or Designee will educate nursing staff to follow the Resident care plan for call bell placement and catheter collection bags.	10/25/2018

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F 656	Continued From page 31 The comprehensive care plan for Resident # 53 with a revision date of 06/21/2018 documented, Focus: (Resident# 53) has indwelling Foley catheter. 16 FR (French) with 10 ml (milliliter balloon r/t (related to) urinary retention." Under "Interventions it documented, "CATHETER: (Resident # 53) has a 16 FR (French) Foley catheter. Position catheter bag and tubing below the level of the bladder and away from the entrance room door. Cover with privacy bag as indicated." On 10/03/18 3:28 p.m., an interview was conducted with LPN (licensed practical nurse) # 2. When asked where Resident # 53's catheter collection bag and tubing was located, LPN # 2 stated, 'In front of the door." When asked why she entered Resident # 53's room at 3:24 p.m., LPN # 2 stated, "I saw the catheter bag was not in the privacy bag completely and I replaced so it was out of sight." When asked about the placement of a resident's catheter collection bag, LPN # 2 stated, "The bag should in a privacy so it can't be seen." When asked to describe the purpose of the care plan LPN # 2 stated, "It tells you what you need to do." When asked if it is documented on the care plan is it something that needs to be followed, LPN # 2 stated, "Yes." LPN # 2 was then asked to review Resident # 53's indwelling catheter care plan and the intervention that documented, "CATHETER: (Resident # 53) has 16 FR (French) Foley catheter. Position catheter bag and tubing below the level of the bladder and away from the entrance room door. Cover with privacy bag as indicated. Revision on: 06/21/2018." When asked if the care plan for Resident # 53's catheter was being followed, LPN # 2 stated, "No."	F 656	**4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?** DON and/or Designee will audit Residents with a care plan for indwelling catheter x3 weeks to ensure continued compliance with the care plan. DON and/or Designee will audit Residents with a care plan on call bell placement x3 weeks to ensure continued compliance with the care plan. DON will report results to the QA committee. Findings and results will be reflected in the QA minutes.	11/16/2018 11/16/2018 11/16/2018

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The facility's policy "Care Plan Policy" documented, "Purpose: Nursing care plans are arranged into three parts which includes Care Plan Problem, Care Plan Goal, and Care Plan Interventions which should be utilized to provide individualized care according to the needs of the resident at (Name of Nursing Home)." Under "Procedure" it documented, "Facility staff should utilize Plan of care accordingly to ensure resident care is appropriate and follows plan of care."

On 10/03/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

(2) A type of arthritis. It occurs when uric acid builds up in blood and causes inflammation in the joints This information was obtained from the website: https://medlineplus.gov/ency/article/000422.htm.

(3) 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:

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F 656	Continued From page 33 https://medlineplus.gov/paralysis.html. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 2. The facility staff failed to follow the comprehensive care plan for Resident # 15's call bell. Resident # 15 was admitted to the facility on 09/22/17 with diagnoses that included but were not limited to: aphasia (1), dysphagia (2), cerebral infarction (3) and hypertension (4). Resident # 15's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 08/06/18, coded Resident # 15 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. Resident # 15 was coded as totally dependent with the assistance of one staff member for activities of daily living. On 10/02/18 at 1:27 p.m., Resident # 15 was observed. He was in his bed, appeared neat and clean, nonverbal with decreased ROM (range of motion) of his RUE (right upper extremity). Observation of the call bell revealed it was attached to the upper left corner of the fitted sheet covering the mattress above Resident # 15's head. When Resident # 15 was asked to reach for and activate the call bell, he was unable to locate it.	F 656		

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F 656	Continued From page 34 On 10/03/18 at 2:04 p.m., Resident # 15 was in his room reclined in a Gerri chair sitting next to his bed. Observation of Resident # 15's bed revealed the call bell was lying in the middle of the bed. When Resident # 15 was asked to reach for and activate the call bell, he was unable to locate it. The comprehensive care plan for Resident # 15 dated 09/22/2017 documented, "Focus. (Resident # 15) has an ADL (activities of daily living) self-care performance deficit r/t (related to) right sided hemiparesis age, immobility and contracture of right hand." Under "Interventions" it documented, "Encourage the resident to use bell to call for assistance. Date initiated: 09/22/2017." On 10/03/18 at 2:11 p.m., an interview was conducted with CNA (certified nursing assistant) # 2 and # 3. When asked about the placement of a resident's call bell, CNAs # 2 and # 3 stated, "It should be within resident's reach." CNAs # 2 and # 3 were then asked to observe Resident # 15 and the placement of his call bell. They acknowledged Resident # 15 was in a Gerri chair next to his bed and the call bell was in the middle of Resident # 15's bed and that it was not within reach of Resident # 15. When asked if they had brought Resident # 15 back to his room from having lunch." CNAs # 2 and # 3 stated no. On 10/03/18 at 2:17 p.m., an interview was conducted with CNA # 4. When asked about the placement of a resident's call bell, CNA #4 stated, "Make sure the call bell is within his reach." After observing, the position of Resident # 15's call bell CNA # 4 was asked if Resident # 15 could reach the call bell. CNA # 4 stated, "No." When asked	F 656		

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if she brought Resident # 15 back into his room following lunch, CNA # 4 stated, "When I brought him in the room I put him next to the bed and moved the call bell over on the bed and put his hand on it to make sure he could reach it. I have no idea how it was moved." When asked if Resident # 15 had the ability to move the call bell to the middle of the bed from his position, CNA # 4 stated, "No."

On 10/03/18 3:28 p.m., an interview was conducted with LPN (licensed practical nurse) # 2. When asked to describe the purpose of the care plan, LPN # stated, "It tells you what you need to do." When asked if it is documented on the care plan is it something that needs to be followed, LPN stated, "Yes." After being informed of the observations of Resident # 15's call bell, LPN # 2 was then asked to review Resident # 15's ADL care plan and the intervention that documented, "Encourage the resident to use bell to call for assistance. Date initiated: 09/22/2017." When asked if the care plan for Resident # 15's call bell was being followed, LPN # 2 stated, "No."

On 10/03/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) 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.htm

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F 656	Continued From page 36 I (2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (3) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm . (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 656	**F657** **1. How will corrective action be accomplished for those residents found to be affected by the deficient practice?** The care plan for Resident #4 will be revised to include falls occurring on 10/1/2017 and 11/11/2017.	11/16/2018
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657	**2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** DON and/or Designee will audit resident falls within 30 days to ensure that care plans have been revised, reflecting falls.	11/16/2018

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F 657	Continued From page 37 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to review and/or revise the comprehensive care plan for one of 24 residents in the survey sample, Residents #4. The facility staff failed to review and/or revise Resident #4's comprehensive care plan when the resident fell on 10/1/17 and 11/11/17. The findings include: Resident #4 was admitted to the facility on 7/29/13. Resident #4's diagnoses included but were not limited to anxiety disorder, urinary tract infection and high cholesterol. Resident #4's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/9/18, coded the resident's cognition as severely impaired. Section J coded Resident #4 as not having any falls since the prior assessment. Review of Resident #4's clinical record revealed	F 657	**3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?** DON will educate members of the nursing clinical team to ensure that revisions are made to care plans following falls. **4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?** DON and/or designee will monitor care plans of residents with falls x3 weeks to ensure revisions have been completed.	11/16/2018 11/16/2018

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F 657	Continued From page 38 the resident was observed lying on the floor beside her bed on 10/1/17 and was observed lying on the floor in the bathroom on 11/11/17. Review of Resident #4's comprehensive care plan initiated on 5/23/16 failed to reveal the care plan was reviewed and/or revised for the 10/1/17 and 11/11/17 falls. On 10/3/18 at 2:14 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 confirmed residents' care plans should be reviewed after each fall. On 10/3/18 at 2:41 p.m., RN #2 confirmed she could not find evidence that Resident #4's care plan was reviewed or revised after the resident fell on 10/1/17 and 11/11/17. On 10/3/18 at 5:07 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Care Plan Policy" documented, "Purpose: Nursing care plans are arranged into the three parts which include Care Plan Problem, Care Plan Goal, and Care Plan Interventions which should be utilized to provide individualized care according to the needs of the residents at (name of facility)... Reviews to the care plan will be completed as follows: -Quarterly -Changes in the plan of care for the resident -Readmission..." No further information was presented prior to exit.	F 657	DON will report results to the QA committee. Findings and results will be reflected in the QA minutes	11/16/2018
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		

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F 695	Continued From page 39 § 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, facility document review, and clinical record review it was determined that the facility staff failed to provide respiratory care and services for one of 24 residents in the survey sample, Resident # 41. The facility staff failed to store Resident # 41's nasal cannula and oxygen tuning in a sanitary manner. The findings include: Resident # 41 was admitted to the facility on 12/28 /2008 with diagnoses that included but were not limited to: heart disease (1), atrial fibrillation (2), multiple sclerosis (3) and hypertension (4). Resident # 41's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/05/18, coded Resident # 41 as scoring a 9 (nine) on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 (nine) - being moderately impaired of cognition for making daily decisions. Resident # 41 was coded as requiring limited to extensive assistance of one staff member for activities of	F 695	**F695** **1. How will corrective action be accomplished for those residents found to be affected by the deficient practice?** The oxygen bag and tubing for Resident #41 was removed from the room. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** DON and/or Designee will audit Residents with oxygen stored within their rooms to ensure nasal canula and oxygen tubing are stored in a sanitary manner.	10/3/2018 11/16/2018

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F 695	Continued From page 40 daily living. On 10/02/18 at 2:40 p.m., an observation of Resident # 41's oxygen concentrator revealed it was on the left side of the bed against the wall. The oxygen concentrator was off. Observation of the oxygen tubing and nasal cannula revealed it was uncovered and lying on the floor under the bed. On 10/02/18 at 5:50 p.m., an observation of Resident # 41's oxygen concentrator revealed it was on the left side of the bed against the wall. The oxygen concentrator was off. Observation of the oxygen tubing and nasal cannula revealed it was uncovered and lying on the floor under the bed. On 10/03/18 at 8:30 a.m., an observation of Resident # 41's oxygen concentrator revealed the oxygen tubing and nasal were removed from Resident # 41's room. The POS (physician order sheet) for Resident # 41 dated October 2018 documented, "Oxygen 2 (two) liters/ (per) minute via (by) nasal cannula or mask, PRN (as needed). Start Date: 09/21/2018." On 10/03/18 at 9:13 a.m., an interview was conducted with LPN (licensed practical nurse) # 1. When asked to describe the procedure for the storage of a nasal cannula and oxygen tubing when not in use, LPN #1 stated, "Keep it in a zip lock bag on the oxygen concentrator." When informed of the observations of Resident # 41's oxygen tubing and nasal cannula lying on the floor under Resident # 41's bed, LPN # 1 stated she was not aware of it and that it should not	F 695	**3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?** DON and/or Designee will educate nursing staff on sanitary storage of nasal canula and oxygen tubing. **4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?** DON and/or Designee will monitor nasal canula and oxygen tubing to ensure sanitary storage weekly x 3 weeks. DON will report results to the QA committee. Findings and results will be reflected in the QA minutes.	10/25/2018 11/16/2018 11/16/2018

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F 695	Continued From page 41 have stored like that." The facility's policy "Infection Control - Respiratory Equipment" documented, "Facility staff should ensure that respiratory related tubing is bagged and stored appropriately when not in use. Bags containing respiratory equipment supplies should be dated and placed in a location to maintain adequate infection control." On 10/093/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) 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. It's the major reason people have heart attacks. Other kinds of heart problems may happen to the valves in the heart, or the heart may not pump well and cause heart failure. Some people are born with heart disease. This information was obtained from the website: https://medlineplus.gov/heartdiseases.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. (3) A nervous system disease that affects your	F 695		

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F 695	Continued From page 42 brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. They can include visual disturbances, muscle weakness, trouble with coordination and balance, sensations such as numbness, prickling, or "pins and needles" and thinking and memory problems. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 695	**F756** **1. How will corrective action be accomplished for those residents found to be affected by the deficient practice?** Monthly drug regimen reviews have been completed by the Physician for Resident's #67, #25, #5, #13, and #4 **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** DON/ Designee will audit monthly regimen reviews made within the last 30 days to ensure that pharmacy recommendations have been addressed by Physician.	11/16/2018 11/16/2018
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical	F 756		

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F 756	Continued From page 43 director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility document review, it was determined that the facility staff failed to develop a medication regimen review policy that included time frames to address recommendations from the pharmacist to the physician for 5 of 24 residents, residents #67, #25, #5, #13, and #4. 1. For Resident #67, the facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations. 2. For Resident #25, the facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations. 3. For Resident #5, the facility staff failed to	F 756	**3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?** DON has revised the policy on medication regimen review to include time frame for physician to respond to Pharmacy recommendations. DON will educate Physicians on the time frame that they are to respond to medication regimen reviews.	11/16/2018 11/16/2018

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F 756	Continued From page 44 ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations. 4. For Resident #13, the facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations. 5. The facility staff failed to develop and implement policies that addressed the time frames of the steps of the medication regimen review to guide staff on the process for acting on irregularities reported by the pharmacist for Resident #4. The findings include: 1. The facility staff failed to develop and implement policies that addressed the time frames of the steps of the medication regimen review to guide staff on the process for acting on irregularities reported by the pharmacist for Resident #67. Resident #67 was admitted to the facility on 9/29/17 with the diagnoses of but not limited to seizures, depression, anxiety, macular degeneration, osteoarthritis, intervertebral disc degeneration, neuropathy, and Alzheimer's disease. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 9/23/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living and as incontinent of bowel and bladder.	F 756	**4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?** The facility will monitor the monthly drug regimen reviews completed x30 days to ensure timely Physician response.	11/12/2018
			DON will report results to the QA committee. Findings and results will be reflected in the QA minutes	11/16/2018

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F 756	Continued From page 45 A review of the clinical record revealed the "Consultant Pharmacist's Medication Regimen Review" form for each month of 2018 from January through September. There were no recommendations made to the resident's medication regimen. A review of the facility policy, "Pharmacy Services" documented, "Purpose: To ensure the residents of (facility) are receiving safe and appropriate medications, at the therapeutic dosage, to promote the best quality of life and limit adverse reactions, while treating medical conditions. Procedure: *The facility staff will contract pharmacy services to promote safe and effective medication usage for the residents who reside in the facility on a regular and emergency basis. *The pharmacist will work with facility staff, residents and families and physicians to ensure appropriate pharmaceutical services, which supports the residents' needs, are met. *Pharmaceutical services to include, but not be limited to acquiring, receiving, dispensing, administering, disposing, labeling and storing medications. *A pharmacy stat box will be available with a select list of medication to be on hand for emergency use. *In the event of a medication not being available, the facility will communicate with the pharmacy and physician to determine if an alternative may be ordered. Licensed nursing staff will receive orders as indicated. *Pharmacist will review each resident's medication regimen at least monthly, and as indicated, to try to minimize adverse effects that may be caused by medication therapy and adverse reactions. *Recommendations and irregularities will be reported to the facility staff and will be documented as indicated. *The facility	F 756		

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F 756	Continued From page 46 will maintain record of pharmacist reviews for all residents in a readily available location. *Facility staff will monitor residents for side effects and med to med interactions and report any change in condition to the physician as indicated." The policy did not specify any time frames in which the physician must address any pharmacy recommendations. On 10/3/18 at 12:53 p.m., in an interview with the DON (director of nursing), ASM [administrative staff member] #1, she stated, "I spoke to the pharmacist and he stated that if it was non urgent the expectation is the physician reviews them the next time he is in to see the patient. Our doctors look at them on a weekly basis and we follow up to make sure we get replied back. They are placed in the MD (medical doctor) folder until they look at them. It does not get filed until they look at it and made a recommendation. The policy does not state any time frames." On 10/3/18 at 5:12 p.m., the ASM #1 and ASM #2 (Administrative Staff Members - the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was provided by the end of the survey. 2. For Resident #25, the facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations. Resident #25 was admitted to the facility on 1/9/16 with the diagnoses of but not limited to osteoarthritis, depression, high blood pressure,	F 756		

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F 756	Continued From page 47	F 756		

anxiety, insomnia, attention deficit disorder, and Alzheimer's disease. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 8/19/18. The resident was coded as being mildly impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and toileting; extensive care for transfers, dressing, and hygiene; supervision for eating; and was incontinent of bowel and bladder.

A review of the clinical record revealed the "Consultant Pharmacist's Medication Regimen Review" form for each month of 2018 from January through September. A recommendation was made on 4/24/18 to the resident's medication regimen. The recommendation was addressed by the physician on 4/25/18. The recommendation was regarding the resident's use of Celecoxib [1] 200 mg (milligrams) daily, and to consider a medication to reduce the risk of stomach irritation or bleed related to the use of the Celecoxib. The physician ordered Protonix [2] 20 mg daily on 4/25/18.

A review of the facility policy, "Pharmacy Services" documented, "Purpose: To ensure the residents of (facility) are receiving safe and appropriate medications, at the therapeutic dosage, to promote the best quality of life and limit adverse reactions, while treating medical conditions. Procedure: *The facility staff will contract pharmacy services to promote safe and effective medication usage for the residents who reside in the facility on a regular and emergency basis. *The pharmacist will work with facility staff, residents and families and physicians to ensure appropriate pharmaceutical services, which supports the residents' needs, are met.

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F 756	Continued From page 48 *Pharmaceutical services to include, but not be limited to acquiring, receiving, dispensing, administering, disposing, labeling and storing medications. *A pharmacy stat box will be available with a select list of medication to be on hand for emergency use. *In the event of a medication not being available, the facility will communicate with the pharmacy and physician to determine if an alternative may be ordered. Licensed nursing staff will receive orders as indicated. *Pharmacist will review each resident's medication regimen at least monthly, and as indicated, to try to minimize adverse effects that may be caused by medication therapy and adverse reactions. *Recommendations and irregularities will be reported to the facility staff and will be documented as indicated. *The facility will maintain record of pharmacist reviews for all residents in a readily available location. *Facility staff will monitor residents for side effects and med to med interactions and report any change in condition to the physician as indicated." The policy did not specify any time frames in which the physician must address any pharmacy recommendations. On 10/3/18 at 12:53 p.m., in an interview with the DON (director of nursing), ASM [administrative staff member] #1, she stated, "I spoke to the pharmacist and he stated that if it was non urgent the expectation is the physician reviews them the next time he is in to see the patient. Our doctors look at them on a weekly basis and we follow up to make sure we get replied back. They are placed in the MD (medical doctor) folder until they look at them. It does not get filed until they look at it and made a recommendation. The policy does not state any time frames."	F 756		

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F 756	Continued From page 49 On 10/3/18 at 5:12 p.m., the ASM #1 and ASM #2 (Administrative Staff Members - the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was provided by the end of the survey. [1] Celecoxib - "...is used to relieve pain, tenderness, swelling and stiffness caused by osteoarthritis..." Information obtained from https://medlineplus.gov/druginfo/meds/a699022.html [2] Protonix - "....is used to treat gastroesophageal reflux disease (GERD), a condition in which backward flow of acid from the stomach causes heartburn and possible injury of the esophagus....is used to treat the symptoms of GERD, allow the esophagus to heal, and prevent further damage to the esophagus. It is also used to treat conditions where the stomach produces too much acid...." Information obtained from https://medlineplus.gov/druginfo/meds/a601246.html 3. For Resident #5, the facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations. Resident #5 was admitted to the facility on 6/25/18 with the diagnoses of but not limited to epilepsy, cerebrovascular disease, stroke, kidney disease, Alzheimer's disease, neurogenic bladder, diabetes, dementia, and deep vein	F 756		

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thrombosis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/13/18. The resident was coded as being severely impaired in making daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, eating, toileting, and hygiene; and was incontinent of bowel and bladder.

A review of the clinical record revealed the "Consultant Pharmacist's Medication Regimen Review" form for each month of 2018 from January through September. There were no recommendations made to the resident's medication regimen.

A review of the facility policy, "Pharmacy Services" documented, "Purpose: To ensure the residents of (facility) are receiving safe and appropriate medications, at the therapeutic dosage, to promote the best quality of life and limit adverse reactions, while treating medical conditions. Procedure: *The facility staff will contract pharmacy services to promote safe and effective medication usage for the residents who reside in the facility on a regular and emergency basis. *The pharmacist will work with facility staff, residents and families and physicians to ensure appropriate pharmaceutical services, which supports the residents' needs, are met. *Pharmaceutical services to include, but not be limited to acquiring, receiving, dispensing, administering, disposing, labeling and storing medications. *A pharmacy stat box will be available with a select list of medication to be on hand for emergency use. *In the event of a medication not being available, the facility will communicate with the pharmacy and physician to

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F 756	Continued From page 51 determine if an alternative may be ordered. Licensed nursing staff will receive orders as indicated. *Pharmacist will review each resident's medication regimen at least monthly, and as indicated, to try to minimize adverse effects that may be caused by medication therapy and adverse reactions. *Recommendations and irregularities will be reported to the facility staff and will be documented as indicated. *The facility will maintain record of pharmacist reviews for all residents in a readily available location. *Facility staff will monitor residents for side effects and med to med interactions and report any change in condition to the physician as indicated." The policy did not specify any time frames in which the physician must address any pharmacy recommendations. On 10/3/18 at 12:53 p.m., in an interview with the DON (director of nursing), ASM [administrative staff member] #1, she stated, "I spoke to the pharmacist and he stated that if it was non urgent the expectation is the physician reviews them the next time he is in to see the patient. Our doctors look at them on a weekly basis and we follow up to make sure we get replied back. They are placed in the MD (medical doctor) folder until they look at them. It does not get filed until they look at it and made a recommendation. The policy does not state any time frames." On 10/3/18 at 5:12 p.m., the ASM #1 and ASM #2 (Administrative Staff Members - the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was provided by the end of the survey.	F 756		

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4. For Resident #13, the facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations.

Resident #13 was admitted to the facility on 12/10/15 with the diagnoses of but not limited to dementia, psychosis, depression, hallucinations, high blood pressure, osteoporosis, anxiety, hernia, hepatitis B, deep vein thrombosis, atrial fibrillation, and Parkinson's disease. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 7/21/18. The resident was coded as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting, and hygiene; limited assistance for eating; and was incontinent of bowel and bladder.

A review of the clinical record revealed the "Consultant Pharmacist's Medication Regimen Review" form for each month of 2018 from January through September. There was a recommendation dated 9/20/18 for considering tapering the Clozapine [1] 12.5 mg (milligram) every morning and 25 mg every night. As of 10/4/18, it had not been signed by the physician as reviewed and acted upon.

A review of the facility policy, "Pharmacy Services" documented, "Purpose: To ensure the residents of (facility) are receiving safe and appropriate medications, at the therapeutic dosage, to promote the best quality of life and limit adverse reactions, while treating medical conditions. Procedure: *The facility staff will

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F 756	Continued From page 53	F 756		

contract pharmacy services to promote safe and effective medication usage for the residents who reside in the facility on a regular and emergency basis. *The pharmacist will work with facility staff, residents and families and physicians to ensure appropriate pharmaceutical services, which supports the residents' needs, are met. *Pharmaceutical services to include, but not be limited to acquiring, receiving, dispensing, administering, disposing, labeling and storing medications. *A pharmacy stat box will be available with a select list of medication to be on hand for emergency use. *In the event of a medication not being available, the facility will communicate with the pharmacy and physician to determine if an alternative may be ordered. Licensed nursing staff will receive orders as indicated. *Pharmacist will review each resident's medication regimen at least monthly, and as indicated, to try to minimize adverse effects that may be caused by medication therapy and adverse reactions. *Recommendations and irregularities will be reported to the facility staff and will be documented as indicated. *The facility will maintain record of pharmacist reviews for all residents in a readily available location. *Facility staff will monitor residents for side effects and med to med interactions and report any change in condition to the physician as indicated."

The policy did not specify any time frames in which the physician must address any pharmacy recommendations.

On 10/3/18 at 12:53 p.m., in an interview with the DON (director of nursing), ASM [administrative staff member] #1, she stated, "I spoke to the pharmacist and he stated that if it was non urgent the expectation is the physician reviews them the

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F 756	Continued From page 54	F 756		

next time he is in to see the patient. Our doctors look at them on a weekly basis and we follow up to make sure we get replied back. They are placed in the MD (medical doctor) folder until they look at them. It does not get filed until they look at it and made a recommendation. The policy does not state any time frames."

On 10/3/18 at 5:12 p.m., the ASM #1 and ASM #2 (Administrative Staff Members - the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was provided by the end of the survey.

[1] Clozapine - "Clozapine is used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) in patients who have not been helped by other medications or who have tried to kill themselves and are likely to try to kill or harm themselves again. Clozapine is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain."
Information obtained from https://medlineplus.gov/druginfo/meds/a691001.html

5. The facility staff failed to develop and implement policies that addressed the time frames of the steps of the medication regimen review to guide staff on the process for acting on irregularities reported by the pharmacist for Resident #4.

Resident #4 was admitted to the facility on 7/29/13. Resident #4's diagnoses included but

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F 756	Continued From page 55 were not limited to anxiety disorder, urinary tract infection and high cholesterol. Resident #4's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/9/18, coded the resident's cognition as severely impaired. Review of Resident #4's clinical record revealed monthly pharmacy medication regimen reviews for April 2018 through September 2018. The reviews documented no new irregularities. However, the facility staff failed to develop and implement policies that addressed the time frames of the steps of the medication regimen review to guide staff on the process for acting on any irregularities reported by the pharmacist. A review of the facility policy, "Pharmacy Services" documented, "Purpose: To ensure the residents of (facility) are receiving safe and appropriate medications, at the therapeutic dosage, to promote the best quality of life and limit adverse reactions, while treating medical conditions. Procedure: *The facility staff will contract pharmacy services to promote safe and effective medication usage for the residents who reside in the facility on a regular and emergency basis. *The pharmacist will work with facility staff, residents and families and physicians to ensure appropriate pharmaceutical services, which supports the residents' needs, are met. *Pharmaceutical services to include, but not be limited to acquiring, receiving, dispensing, administering, disposing, labeling and storing medications. *A pharmacy stat box will be available with a select list of medication to be on hand for emergency use. *In the event of a medication not being available, the facility will communicate with the pharmacy and physician to	F 756		

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F 756	Continued From page 56 determine if an alternative may be ordered. Licensed nursing staff will receive orders as indicated. *Pharmacist will review each resident's medication regimen at least monthly, and as indicated, to try to minimize adverse effects that may be caused by medication therapy and adverse reactions. *Recommendations and irregularities will be reported to the facility staff and will be documented as indicated. *The facility will maintain record of pharmacist reviews for all residents in a readily available location. *Facility staff will monitor residents for side effects and med to med interactions and report any change in condition to the physician as indicated." On 10/3/18 at 12:53 p.m., in an interview with ASM (administrative staff member) #2 (the director of nursing), she stated, "I spoke to the pharmacist and he stated that if it was non urgent the expectation is the physician reviews them the next time he is in to see the patient. Our doctors look at them on a weekly basis and we follow up to make sure we get replied back. They are placed in the MD (medical doctor) folder until they look at them. It does not get filed until they look at it and made a recommendation. The policy does not state any time frames." On 10/3/18 at 5:07 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. No further information was presented prior to exit.	F 756		
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	F 880		

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F 880	Continued From page 57 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 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	F 880	**F880** **1. How will corrective action be accomplished for those residents found to be affected by the deficient practice?** DON and/or designee provided treatment following proper infection control practices for Resident #34. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** DON and/or designee will observe the care of residents with current orders for treatments to ensure infection control practices are followed during the administration of treatments.	10/04/2018 11/16/2018

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F 880	Continued From page 58 (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. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review it was determined that the facility staff failed to follow infection control practices for one of 24 residents in the survey sample, Resident # 34. The facility staff failed to follow infection control practices while administering a treatment to Resident # 34. During a wound care observation, LPN (licensed practical nurse) # 1 failed to place a clean barrier on the bed under Resident # 34's right foot while cleansing a vascular wound.	F 880	**3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?** DON and/or designee will educate licensed nursing staff on the infection control practice of placing a clean barrier between the bed and the resident, while administering a treatment.	11/16/2018

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F 880	Continued From page 59 The findings include: Resident # 34 was admitted to the facility on 05/23/17 with diagnoses that included but were not limited to: gastroesophageal reflux disease (1), gout (2), peripheral vascular disease (3) and hypertension (4). Resident # 34's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 08/26/18, coded Resident # 34 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. Resident # 34 was coded as requiring limited to extensive assistance of one staff member for activities of daily living. On 10/03/18 at 9:35 a.m., an observation of LPN (licensed practical nurse) # 1 providing Resident # 34's wound care was conducted. Upon entering Resident # 34's room LPN # 1 placed the wound care supplies on a clean towel at the foot of Resident # 34's bed. LPN # 1 informed Resident # 34 of what was going to occur regarding his wound care for his number one right toe (big toe) and Resident # 34 verbally acknowledged and consented. LPN # 1 washed her hands and donned a clean pair of disposable gloves, removed Resident # 34's sock, removed gloved, washed her hands, donned a clean pair of disposable gloves, began removing the old dressing. Observation of the old dressing removal revealed the gauze was stuck to the wound. LPN # 1 told Resident # 34 she would use some saline to loosen the dressing so it did not pull on the wound. LPN # 1 then opened a plastic bottle of saline, poured some over the wound and gauze loosening the gauze. LPN # 1	F 880	**4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?** DON and/or designee will observe the infection control practices during wound care on 1 resident/week x3 weeks to ensure compliance is maintained. DON will report results to the QA committee. Findings and results will be reflected in the QA minutes.	11/16/2018 11/16/2018

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F 880	Continued From page 60 then removed the dressing from Resident # 34's number one toe on the right foot. Further observation of LPN # 1 procedure of applying the saline to loosen the gauze revealed that excess saline from the wound on the toe flowed down Resident # 34's right foot and dripped onto the bed sheet. After removing the old dressing LPN # 1 washed her hands, donned a clean pair of disposable gloves, placed a clean pad under Resident # 34's right foot, cleaned the wound with saline, removed her gloves, washed her hands and donned a clean pair of disposable gloves, applied santyl (5) and a clean dressing. On 01/03/18 at 11:55 a.m., an interview was conducted with LPN # 1. When asked to describe the process they follow for infection control during wound care, LPN # 1 stated, "Wash hands, remove old dressing, wash hands again, clean the wound, apply the dressing according to the physician's orders, wash hands, and remove all soiled items from the trash can." When asked about providing a clean barrier, LPN # 1 stated, "I would place a barrier under the body part or dressing." When informed of the observation of the saline dripping onto Resident # 34's bed, LPN # 1 stated, I should have put a barrier down under his feet when I started." The facility's policy "Wound Care" documented, "Apply appropriate barriers to location of treatment as indicated." On 10/093/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	F 880		

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SKYLINE TERRACE CONV HOME	PO BOX 558 WOODSTOCK, VA 22664

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 61 References: (1) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (2) A type of arthritis. It occurs when uric acid builds up in blood and causes inflammation in the joints This information was obtained from the website: https://medlineplus.gov/ency/article/000422.htm. (3) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) An FDA-approved prescription medicine that removes dead tissue from wounds so they can start to heal. Proper wound care management is important to help remove nonliving tissue from your wound properly. This information was obtained from the website: https://santyl.com/	F 880		