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PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 2/4/20 through 2/6/20. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/4/20 through 2/6/20. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Four complaints were investigated during the survey. The census in this 120 certified bed facility was 119 at the time of the survey. The survey sample consisted of 44 current Resident reviews and 9 closed record reviews.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		3/7/20

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

Electronically Signed | 02/20/2020

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F 578	Continued From page 1 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to ensure residents were given the opportunity to formulate an advance directive for 16 of 53 residents (#502, #503, #93, #302, #304, #79, #352, #353, #4, #255, #38, #81, #410, #202, #97, and #213) in the survey sample. The findings included: 1. Resident #502 was admitted to the facility on	F 578	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged	

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F 578	Continued From page 2 1/27/20 with diagnoses that included but were not limited to high blood pressure and chronic diastolic heart failure. Resident #502 did not have a completed admission MDS (minimum data set) assessment but was documented in an admission nursing note dated 1/27/20 as being "alert with some confusion." Review of Resident #502's February 2020 POS (physician order summary) revealed that Resident #502 had an order to be a DNR (Do not Resuscitate). This order was initiated on 1/27/20. Further review of Resident #502's clinical record failed to evidence that she had an advanced directive or was given the opportunity to formulate an advanced directive. On 2/5/2020 at 4:11 p.m., an interview was conducted with ASM (Administrative Staff Member) #1, the Administrator. ASM #1 stated that when residents were admitted to the facility, facility staff will go over an admission contract/agreement on an electronic tablet and two pages of the "Self Determination Rights" policy. ASM #1 stated that residents sign these documents through the electronic tablet. ASM #1 stated that these documents go over advanced directives. ASM #1 stated that the electronic tablet would not populate these documents for the residents, so she could not show evidence that this process was being done. ASM #1 presented a paper copy of the admission contract with pages one through 4 blank and two pages of the "Self Determination Policy" blank. ASM #1 stated that the blank copy was the "Electronic Backup Packet" and an example of what these documents looked like on the tablet. ASM #1 also stated that staff were not documenting when they	F 578	deficiencies cited have been or will be completed by the dates indicated. 578 1. Residents #502, 503, 302, 304, 79, 353, 4, 255, 38, 81, 410, 202, and 213 were reviewed and given the opportunity to formulate an advance directive. Resident #93 discharged on 2/5/20. Resident #352 discharged on 2/11/20. Resident #97 discharged on 2/11/20. 2. Current residents were reviewed to ensure that an opportunity to formulate an advance directive was given. 3. The Administrative staff will be educated on ensuring that an opportunity to formulate an advance directive is given at time of admission. 4. The Administrator will complete a random weekly review of documentation that an opportunity to formulate an advance directive was given at time of admission. 5. Results of the monitoring will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: March 7, 2020	

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went over advanced directives, if a resident had an advanced directive or wanted to formulate one. ASM #1 stated that staff were also not asking residents who did not have an advanced directive if they wanted to formulate one. When asked if they were able to find an advance directive for Resident #502, ASM #1 stated that they didn't have it.

On 2/6/2020 at 3:26 p.m., ASM #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

2. Resident #503 was admitted to the facility on 1/25/20 with diagnoses that included but were not limited to cellulitis (skin infection) of the left and right lower limb, Lymphedema, and high blood pressure. Resident #503's did not have a completed MDS (minimum data set) assessment but was documented in January nursing notes as being alert and oriented x 4 (person, place, time and situation).

Review of Resident #503's February 2020 POS (physician order summary) revealed that Resident #503 had an order to be a Full Code. This order was initiated on 1/25/20.

Further review of Resident #503's clinical record failed to evidence that she had an advanced directive or was given the opportunity to formulate an advanced directive.

On 2/5/2020 at 4:11 p.m., an interview was conducted with ASM (Administrative Staff Member) #1, the Administrator. ASM #1 stated that when residents were admitted to the facility, facility staff will go over an admission

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contract/agreement on an electronic tablet and two pages of the "Self Determination Rights" policy. ASM #1 stated that residents sign these documents through the electronic tablet. ASM #1 stated that these documents go over advanced directives. ASM #1 stated that the electronic tablet would not populate these documents for the residents, so she could not show evidence that this process was being done. ASM #1 presented a paper copy of the admission contract with pages one through 4 blank and two pages of the "Self Determination Policy" blank. ASM #1 stated that the blank copy was the "Electronic Backup Packet" and an example of what these documents looked like on the tablet. ASM #1 also stated that staff were not documenting when they went over advanced directives, if a resident had an advanced directive or wanted to formulate one. ASM #1 stated that staff were also not asking residents who did not have an advanced directive if they wanted to formulate one. When asked if they were able to find an advanced directive for Resident #503, ASM #1 stated that they didn't have it.

On 2/6/2020 at 3:26 p.m., ASM #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

3. Resident #93 was admitted to the facility on 1/8/20 with diagnoses that included but were not limited to Wedge compression fracture of second lumbar vertebrae, and repeated falls. Resident #93's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 1/15/2020. Resident #93 was coded as being intact in cognitive function scoring 15 out of

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possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #93's February 2020 POS (physician order summary) revealed that Resident #93 had an order to be a Full Code. This order was initiated on 1/8/2020.

Further review of Resident #93's clinical record failed to evidence that she had an advanced directive or was given the opportunity to formulate an advanced directive.

On 2/5/2020 at 4:11 p.m., an interview was conducted with ASM (Administrative Staff Member) #1, the Administrator. ASM #1 stated that when residents were admitted to the facility, facility staff will go over an admission contract/agreement on an electronic tablet and two pages of the "Self Determination Rights" policy. ASM #1 stated that residents sign these documents through the electronic tablet. ASM #1 stated that these documents go over advanced directives. ASM #1 stated that the electronic tablet would not populate these documents for the residents, so she could not show evidence that this process was being done. ASM #1 presented a paper copy of the admission contract with pages one through 4 blank and two pages of the "Self Determination Policy" blank. ASM #1 stated that the blank copy was the "Electronic Backup Packet" and an example of what these documents looked like on the tablet. ASM #1 also stated that staff were not documenting when they went over advanced directives, if a resident had an advanced directive or wanted to formulate one. ASM #1 stated that staff were also not asking residents who did not have an advanced directive if they wanted to formulate one. When

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asked if they were able to find an advanced directive for Resident #93, ASM #1 stated that they didn't have it.

On 2/6/2020 at 3:26 p.m., ASM #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

4. Resident #302 was admitted to the facility on 1/22/20 with diagnoses to include but not limited to Intracerebral Hemorrhage and Chronic Obstructive Pulmonary Disease.

Due to Resident #302's recent admission date a Comprehensive Minimum Data Set has not been completed at the time of survey but was in progress.

Resident #302's Baseline Care Plan was reviewed and there was no focus to include Advance Directives for the resident.

Resident #302's Electronic Medical Record was reviewed and revealed no evidence of Advance Directive Documents.

On 2/5/20 at approximately 10:00 A.M. the Nurse Consultant was asked for facility documents to support that Resident #302 was asked about advance directives, provided an advance directive and/or given information to formulate an advance directive.

On 2/5/20 at 10:45 P.M. the Nurse Consultant stated, "We don't have any evidence to support the resident was asked about advance directives or given information to formulate an advance directive." The Nurse Consultant was asked who was responsible for reviewing advance directive

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information with the residents. The Nurse Consultant stated, "Per the facility policy it is the responsibility of the Admission Director."

On 2/5/20 at 10:50 A.M. an interview was conducted with the Admissions Director regarding reviewing Advance Directives with new admissions. The Admission Director stated, "I only review what is on the template for new admissions. We use a tablet based admission process and advance directives is not in my template."

On 2/6/20 at 3:30 P.M. a pre-exit debriefing was conducted with the Administer, the Director of Nursing and the Nurse Consultant were the above information was shared. Prior to exit no further information was shared.

5. Resident #304 was admitted tot he facility on 1/30/20 with diagnoses to include but not limited to Diabetes Mellitus and Dementia.

Due to Resident #304's recent admission date a Comprehensive Minimum Data Set has not been completed at the time of survey but was in progress.

Resident #304's Baseline Care Plan was reviewed and there was no focus to include Advance Directives for the resident.

Resident #304's Electronic Medical Record was reviewed and revealed no evidence of Advance Directive Documents.

On 2/5/20 at approximately 10:00 A.M. the Nurse Consultant was asked for facility documents to support that Resident #304 was asked about

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advance directives, provided an advance directive and/or given information to formulate an advance directive.

On 2/5/20 at 10:45 P.M. the Nurse Consultant stated, "We don't have any evidence to support the resident was asked about advance directives or given information to formulate an advance directive." The Nurse Consultant was asked who was responsible for reviewing advance directive information with the residents. The Nurse Consultant stated, "Per the facility policy it is the responsibility of the Admission Director."

On 2/5/20 at 10:50 A.M. an interview was conducted with the Admissions Director regarding reviewing Advance Directives with new admissions. The Admission Director stated, "I only review what is on the template for new admissions. We use a tablet based admission process and advance directives is not in my template."

On 2/6/20 at 3:30 P.M. a pre-exit debriefing was conducted with the Administer, the Director of Nursing and the Nurse Consultant were the above information was shared. Prior to exit no further information was shared.

6. The facility staff failed to ensure Resident #79 was given the opportunity to formulate an Advance Directive. Resident #79 was admitted to the nursing facility on 01/02/20. Diagnosis for Resident #79 included but not limited to Acute Systolic Congestive Heart Failure.

Review of the clinical record revealed that there were no Advance Directive for Resident #79.

Review of Resident #79's Physician Order Sheet

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(POS) for February 2020 revealed the following order: Full Code starting on 01/07/20.

On 02/05/20 at approximately 1:50 p.m., an interview was conducted with the Administrator, Director of Nursing (DON) and Nurse Consultant who were asked if Resident #79 was given the opportunity to formulate an Advance Directive. The Administrator said they were unable to locate an advanced directive for Resident #79. The Administrator was asked who is responsible for ensuring Resident #79 was given the opportunity to formulate an Advance Directive, she replied, "The Director of Admissions."

An interview was conducted with the Director of Admission on 02/05/20 at approximately 2:45 p.m. She said, no one ever told me I had to follow up if a resident did not have an Advance Directive. I did not realize I had the ability to initiate an advance directive. The Director of Admissions said if the family did not bring in an Advanced Directive or if the resident did not have one; I did not initiate one.

A briefing was held with the Administrator, Director of Nursing and Nurse Consultant on 02/06/20 at approximately 12:50 p.m. The facility did not present any further information about the findings.

7. The facility staff failed to ensure Resident #352 was given the opportunity to formulate an Advance Directive. Resident #352 was originally admitted to the nursing facility on 12/20/19. Diagnosis for Resident #352 included but not limited to Pneumonia.

Review of the clinical record revealed that there

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were no Advance Directive for Resident #352.

Review of Resident #352's Physician Order Sheet (POS) for February 2020 revealed the following order: Full Code starting on 01/30/20.

On 02/05/20 at approximately 1:50 p.m., an interview was conducted with the Administrator, Director of Nursing (DON) and Nurse Consultant who were asked if Resident #79 was given the opportunity to formulate an Advance Directive. The Administrator said they were unable to locate an advanced directive for Resident #79. The Administrator was asked who is responsible for ensuring Resident #79 was given the opportunity to formulate an Advance Directive, she replied, "The Director of Admissions."

An interview was conducted with the Director of Admission on 02/05/20 at approximately 2:45 p.m. She said, no one ever told me I had to follow up if a resident did not have an advanced directive. I did not realize I had the ability to initiate an advance directive. The Director of Admissions said if the family did not bring in an Advance Directive or if the resident did not have one; I did not initiate one.

A briefing was held with the Administrator, Director of Nursing and Nurse Consultant on 02/06/20 at approximately 12:50 p.m. The facility did not present any further information about the findings.

8. The facility staff failed to ensure Resident #353 was given the opportunity to formulate an Advance Directive. Resident #353 was admitted to the nursing facility on 12/05/19. Diagnoses for Resident #353 included but not limited to

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Cerebrovascular accident (CVA).

Review of the clinical record revealed that there were no Advance Directives for Resident #353.

Review of Resident #353's Physician Order Sheet (POS) for February 2020 revealed the following order: Full Code starting on 12/05/19.

On 02/05/20 at approximately 1:50 p.m., an interview was conducted with the Administrator, Director of Nursing (DON) and Nurse Consultant who were asked if Resident #353 was given the opportunity to formulate an Advance Directive. The Administrator said they were unable to locate an advanced directive for Resident #353. The Administrator was asked who is responsible for ensuring Resident #353 was given the opportunity to formulate an Advance Directive, she replied, "The Director of Admissions."

An interview was conducted with the Director of Admission on 02/05/20 at approximately 2:45 p.m. She said, no one ever told me I had to follow up if a resident did not have an advanced directive. I did not realize I had the ability to initiate an advance directive. The Director of Admissions said if the family did not bring in an Advance Directive or if the resident did not have one; I did not initiate one.

A briefing was held with the Administrator on 02/06/20 at approximately 12:50 p.m. The facility did not present any further information about the findings.

9. The facility staff failed to inform and provide Resident #4 an opportunity to formulate an Advance Directive upon admission to the facility.

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Resident #4 was initially admitted to the facility on 01/31/19 and re-admitted to the facility on 07/13/19. Diagnoses for this resident included cerebral infarction, dysphagia, hypertension, type II diabetes mellitus, anemia, major depression and peripheral vascular disease.

A Quarterly Minimum Data Set (MDS) dated 10/19/19 assessed this resident in the area of Speech, Hearing and Vision as being able to understand and respond adequately to simple, direct communication. In the area of Cognitive Patterns this resident had a Brief Interview for Mental Status (BIMS) assess this resident as a (4) four.

A review of the clinical record did not include an Advance Directive.

A review of the Health and Rehabilitation Center Policies included:

(4). indicated: At the time of admission, all Residents who do not have advance directives will be provided with a summary of their individual rights under state law to make medical decisions concerning their care. This information will be presented in the form of a question and answer educational brochure entitled "Your Right to Decide."

(6). The Resident will be given the opportunity by the Health Rehabilitation Center to execute an Advance Medical Directive form.

During an interview on 02/06/20 at 10:30 a.m. with the Administrator she stated, Resident #4 was not provided an Advance Medical Directive upon admission.

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10. The facility staff failed to ensure on admission if Resident #255 had an advance directive or determined if the resident wished to formulate an Advance Directive.

Resident #255 was admitted to the facility on 1/23/20 with diagnoses to include but not limited to diabetes, chronic pain, and acquired right leg above the knee amputation. An admission MDS had not been completed prior to survey. The resident was alert and orientated to person, place and time.

A review of the electronic medical record failed to evidence an Advance Directive. On 2/5/20 a request to the Director of Nursing was made for a copy of the resident's Advance Directive or documentation that at the time of admission the facility determined the resident's wish to formulate an Advance Directive.

The facility was not able to provide any documentation of an Advance Directive of that at the time of admission that the facility determined the resident's wishes to formulate an Advance Directive.

The above findings was shared with the Administrator, the Director of Nursing and the Nurse Consultant during the pre-exit meeting conducted on 2/6/20.

11. Resident #38 was initially admitted to the facility on 12/11/2019. Resident #38 was discharged to the hospital on 12/05/2019 and readmitted to the facility on 12/11/2019. Diagnoses included but were not limited to Unspecified Dislocation of Left Hip, Subsequent Encounter and Chronic Obstructive Pulmonary

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Disease. Resident #38's Minimum Data Set (MDS an assessment protocol) with as Assessment Reference Date of 12/18/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment.

On 02/04/2020 a copy of Resident #38's Advance Directive was requested.

On 02/05/2020 at approximately 12:00 p.m., a group interview was conducted with the Administrator. The Administrator provided a blank copy of the facility policy titled, "Admissions Policies and Procedures" and a copy of the facility Admissions Agreement - Electronic Backup Packet. The Administrator said that the Admissions Director reviews the Admission Agreement with new residents within 24 to 48 hours and that residents are asked to bring in Advance Directives if they have them. When asked if the resident did not have an advance directive was the resident asked if they wanted to formulate one, the Administrator said, "No." The Administrator stated, "Before 2019 the Admission Agreements were handwritten on paper and scanned. After 2019 they were put into an electronic tablet." The Administrator also stated, "The electronic tablet will not populate these documents so we do not have a way to provide copies of the Admission Agreements." The Administrator stated, "Going forward in the future the Admissions Director will review the Admissions Agreement with the residents and will scan pages 1 through 2 and pages 1 through 4 and update to the document tab." Review of the Admissions Agreement revealed a section on page 2 of 2 which reads as follows: "I have been provided with written information regarding my

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rights to make medical decisions under Virginia state law which includes my right to accept or refuse treatment and my right to formulate advance directives."

On 02/05/2020 a copy of Resident #38's Living Will dated 10/11/2019 was received. The facility was unable to provide evidence that the facility had offered the resident an opportunity to formulate an advance directive.

The Administrator, Director of Nursing, Corporate nurse Consultant, Corporate Dietician and Corporate Technician was informed of the finding at the pre-exit meeting on 02/06/2020 at approximately 4:30 p.m. No further information was provided.

12. Resident #81 was initially admitted to the facility on 01/04/2020. Diagnosis included but were not limited to Coronary Artery Disease and Heart Failure. Resident #81's Admission Minimum Data Set (MDS an assessment Protocol) with an Assessment Reference Date of 01/11/2020 was coded with a BIMS (Brief Interview for Mental Status) score of 14 indicating no cognitive impairment.

On 02/04/2020 requested copy of Resident #38's Advance Directive.

On 02/05/2020 at approximately 12:00 p.m., a group interview was conducted with the Administrator. The Administrator provided a blank copy of the facility policy titled, "Admissions Policies and Procedures" and a copy of the facility Admissions Agreement - Electronic Backup Packet. The Administrator said that the Admissions Director reviews the Admission

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Agreement with new residents within 24 to 48 hours and that residents are asked to bring in Advance Directives if they have them. When asked if the resident did not have an advance directive was the resident asked if they wanted to formulate one, the Administrator said, "No." The Administrator stated, "Before 2019 the Admission Agreements were handwritten on paper and scanned. After 2019 they were put into an electronic tablet." The Administrator also stated, "The electronic tablet will not populate these documents so we do not have a way to provide copies of the Admission Agreements." The Administrator stated, "Going forward in the future the Admissions Director will review the Admissions Agreement with the residents and will scan pages 1 through 2 and pages 1 through 4 and update to the document tab." Review of the Admissions Agreement revealed a section on page 2 of 2 which reads as follows: "I have been provided with written information regarding my rights to make medical decisions under Virginia state law which includes my right to accept or refuse treatment and my right to formulate advance directives."

On 02/05/2020 the facility was unable to provide evidence of an advance directive for Resident #81. The facility was unable to provide evidence that the facility had offered the resident an opportunity to formulate an advance directive.

The Administrator, Director of Nursing, Corporate nurse Consultant, Corporate Dietician and Corporate Technician was informed of the finding at the pre-exit meeting on 02/06/2020 at approximately 4:30 p.m. No further information was provided.

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13. Resident #410 was admitted to the facility on 01/20/2020. Diagnosis included but were not limited to Left Hip Fracture, End Stage Renal Disease and Human Immunodeficiency Virus (HIV) Disease. Resident #410's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 01/27/2020 was coded with a BIMS (Brief Interview for Mental Status) score of 13 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #410 as requiring supervision with setup help only for eating, limited assistance of 1 for personal hygiene, extensive assistance of 1 for bed mobility, dressing, toilet use and bathing, and extensive assistance of 2 for transfer.

On 02/04/2020 requested copy of Resident #410's Advance Directive.

On 02/05/2020 at approximately 12:00 p.m., a group interview was conducted with the Administrator. The Administrator provided a blank copy of the facility policy titled, "Admissions Policies and Procedures" and a copy of the facility Admissions Agreement - Electronic Backup Packet. The Administrator said that the Admissions Director reviews the Admission Agreement with new residents within 24 to 48 hours and that residents are asked to bring in Advance Directives if they have them. When asked if the resident did not have an advance directive was the resident asked if they wanted to formulate one, the Administrator said, "No." The Administrator stated, "Before 2019 the Admission Agreements were handwritten on paper and scanned. After 2019 they were put into an electronic tablet." The Administrator also stated,

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"The electronic tablet will not populate these documents so we do not have a way to provide copies of the Admission Agreements." The Administrator stated, "Going forward in the future the Admissions Director will review the Admissions Agreement with the residents and will scan pages 1 through 2 and pages 1 through 4 and update to the document tab." Review of the Admissions Agreement revealed a section on page 2 of 2 which reads as follows: "I have been provided with written information regarding my rights to make medical decisions under Virginia state law which includes my right to accept or refuse treatment and my right to formulate advance directives."

On 02/05/2020 received a copy of Resident #410's Living Will dated 11/01/2019. The facility was unable to provide evidence that the facility had offered the resident an opportunity to formulate an advance directive.

The Administrator, Director of Nursing, Corporate Nurse Consultant, Corporate Dietician and Corporate Technician was informed of the finding at the pre-exit meeting on 02/06/2020 at approximately 4:30 p.m. No further information was provided.

14. Resident #202 was admitted to the nursing facility on 1/23/20 with diagnoses that included traumatic subdural hematoma.

The resident was not due for a Minimum Data Set (MDS) assessment. The admission nursing assessment dated 1/23/20 indicated Resident #202 was alert and oriented times 4 (person, place, time and situation).

Resident #202's Advance Directive signed and

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dated by the resident on 1/17/17 indicated the following:
"I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I will continue to receive treatments to relieve pain and make me comfortable."

The clinical record indicated that the resident was a "full code" which means to administer CPR.

The aforementioned issue was reviewed during the debriefing held on 2/6/20 at 3:15 p.m. with the Administrator, Director of Nursing (DON), Nurse Consultant, Diet Technician and Corporate Dietician. No further information was provided prior to survey exit.

15. Resident #97 was admitted to the nursing facility on 1/13/20 with diagnoses that included fractured cervical vertebrae and syncope.

The resident's Admission Minimum Data Set (MDS) assessment dated 1/20/20 assessed the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident's cognitive skills were intact for daily decision making.

Review of the clinical record on 2/4/20 did not reflect that the resident had an Advanced Directive nor that there was documentation that the facility had offered the resident an opportunity to formulate one.

On 2/5/20 at approximately 3:50 p.m., the Administrator stated, "Going forward we will

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ensure documentation as to whether there is an Advanced Directive or that they were offered to the opportunity to develop one."

On 2/6/20 at 2:30 p.m., the Administrator presented a document that indicated that they reviewed Advanced Directive with Resident #97, signed and dated on 2/6/20 that he elected "not" to formulate one.

The aforementioned issue was reviewed during the debriefing held on 2/6/20 at 3:15 p.m. with the Administrator, Director of Nursing (DON), Nurse Consultant, Diet Technician and Corporate Dietician. No further information was provided prior to survey exit.

16. Resident #213 was admitted to the nursing facility on 1/31/20 with diagnoses that included spinal stenosis and post cervical surgical care.

The resident was not due for a Minimum Data Set (MDS) assessment. The admission nursing assessment dated 1/31/20 indicated Resident #213 was alert and oriented times 4 (person, place, time and situation).

Resident #213's Advance Directive signed and dated by the resident on 1/16/07 indicated the following:
"I do not want life sustaining treatments, such as cardiopulmonary resuscitation (CPR) started. If these treatments are started I want them stopped."

The clinical record indicated that the resident was a "full code" which means to initiate CPR.

The aforementioned issue was reviewed during

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F 578	Continued From page 21 the debriefing held on 2/6/20 at 3:15 p.m. with the Administrator, Director of Nursing (DON), Nurse Consultant, Diet Technician and Corporate Dietician. No further information was provided prior to survey exit. The facility's policy and procedures titled Admission Documents/Patient Self Determination Act dated 2/5/15 indicated "In accordance with the Patient Self-Determination Act (PSDA) passed by congress in 1990, the Admissions Director must ask the patient at the time of admission if he/she has an advanced directive and must also inform the patient at the time of admission about their rights under Virginia law to make decision about their medical care.	F 578		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F 609		3/7/20

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F 609	Continued From page 22 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and review of the facility documentation, the facility staff failed to immediately report to the Administrator or designee an allegation of verbal abuse, and within two hours report the incident to the State survey and certification agency for 2 of 53 residents (Resident #103 and #17) in the survey sample. The findings include: 1. Resident #103 was admitted to the nursing facility on 1/11/19 with diagnoses that included spinal stenosis, cervical spinal fusion, diabetes, high blood pressure and generalized muscle weakness. The resident was discharged home with physical and occupational therapy on 8/22/19 The Minimum Data Set (MDS) prior to the resident's discharge was quarterly dated 7/17/19 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was cognitively intact with the necessary skills for daily decision making. A Facility Reported Incident (FRI) indicated on 6/15/19, Certified Nursing Assistant (CNA) #8 (no	F 609	609 1. Resident #103 was discharged on 8/22/19. Resident #17 is free of verbal assault by other residents. 2. Facility service concerns were reviewed for the past month to ensure that any allegation of abuse was reported in a timely manner. 3. Facility staff will be educated on: " Abuse " Mandated reporting of abuse " Completing a service concern form " Timely Administrative notification of allegations of abuse 4. The Administrator will review service concerns on a weekly basis to ensure that allegations of abuse were reported timely. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: March 7, 2020	

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longer employed by the facility) was observed by CNA #9 (no longer employed by the facility) to use profanity during a conversation with Resident #103. Further documentation from other CNA Staff indicated that it was CNA #8's practice to project negative attitudes towards residents during nursing tasks; for example, vital signs, weights, meal tray set up.

An interview was conducted with CNA #4 on 2/6/20 at 11:00 a.m. She stated she often stepped in when she observed CNA #8 "Out of line" with residents and told him he needed a break. She stated she told the Unit 3 Manager about CNA #8's inappropriate behavior each time, but not sure how things were handled because CNA #8 never changed his attitude toward residents during care. She stated the resident told her the following day (6/16/19) about the incident on 6/15/19 and was still very upset over CNA #8 cursing at her.

The alleged verbal abuse incident was known by the nursing staff on 6/15/19, but they failed to report the incident immediately to the Administrator or designee. The Director of Nursing (DON) reported the incident to the State survey and certification agency on 6/17/19, thus reporting requirements were not met and the incident was not reported within two hours after the allegation was made.

An interview was conducted with the DON on 2/6/20 at 11:20 a.m. She stated, " It can be confusing, but I want to make sure I get this reporting requirement mandate across to all nursing staff and I fully understand how to proceed."

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It was determined that all of the aforementioned nursing staff completed the Abuse and Neglect training and signed they understood the following: "I understand that (name of the facility) requires that I immediately report any and all suspected or witnessed incidents of resident abuse, neglect, exploitation, or any suspicion of death due to abuse and neglect to the Administrator or if in his/her absence, the Director of Nursing."

Random interviews were conducted with two more CNA's:

On 2/6/20 at 1:45 p.m., CNA #4 stated she would report any suspicions of verbal or physical abuse to the nursing supervisor.

On 2/6/20 at 2:00 p.m., CNA #5 said "Ethics is ethics and not one should be subject to verbal or physical abuse. I would report it right away to a charge nurse, supervisor or unit manager."

On 2/6/20 at 3:15 p.m., a debriefing was conducted with the Administrator, DON, Nurse Consultant, Diet Technician and Corporate Dietician. No further information was presented prior to survey exit.

The facility policy and procedure titled Abuse/Neglect/Misappropriation/Crime-Reporting Requirements/Investigations dated 11/30/18 indicated the employees were responsible to immediately report to the Administrator, the Assistant Administrator, to the DON (and in their absence, the immediate supervisor) any and all suspected or witnessed incidents of patient abuse, neglect or exploitation, or any death of a patient that is suspected to have occurred due to abuse, neglect and /or exploitation. The

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Administrator will immediately report to the State Agency, but not later that 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later that 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury.
2. For Resident #17, the facility failed to report a Resident to Resident allegation of verbal abuse within a 2-hour timeframe to the State Survey Agency.

Resident #17 was admitted to the Facility on 11/19/2015 with diagnoses including, but not limited to, stroke, hyperlipidemia, anemia, and hypertension.

Resident #17's most recent MDS (Minimum Data Set) was a quarterly review assessment with an ARD (Assessment Review Date) of 11/20/2019. Resident #7 was coded as cognitively intact, scoring 15 out of possible 15 on the BIMS (brief interview for mental status) exam.

A review of a Facility Reported Incident (FRI) received on 1/10/2020, revealed Resident #17 reported to facility staff on 01/09/2020, an incident occurring on the previous day, 01/08/2020. Resident #17 alleged she was verbally assaulted by another resident, which left her feeling "threatened and disrespected."

Fax confirmation included with the Facility Reported Incident (FRI) report verified that the report was submitted on 01/10/2020 to the State Survey Agency, for an alleged abuse incident reported on 01/09/2020.

During an interview with the facility Administrator

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F 609	Continued From page 26 on 02/06/2020 at approximately 3:00 p.m., when asked about facility practices regarding reporting resident to resident incidents with alleged abuse, the Administrator responded, "We conduct an investigation and report within a 2-hour timeframe."	F 609		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		3/7/20

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F 655	Continued From page 27 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, clinical record review and facility documentation review, the facility staff failed to ensure the 48 hour Baseline Care Plan/Summary was completely developed for 4 out of 53 residents (Resident #352, #202, #97 and #213) in the survey sample. The finding included: 1. Resident #352 was originally admitted to the nursing facility on 12/20/19. Resident #352 was discharged to the local hospital on 1/03/20. Resident #352 was re-admitted to the nursing facility on 01/30/20. Diagnosis for Resident #352 included but not limited to pneumonia. Resident #352's Minimum Data Set (MDS) an annual assessment with an Assessment Reference Date (ARD) of 12/26/19 coded the resident with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. During the initial tour on 02/04/20 at	F 655	655 1. Residents #202, 97, and 213 have received a copy of their Baseline Care Plan/Summary. Resident #352 discharged on 2/11/20. 2. Residents and/or representatives will receive a copy of the resident□s baseline care plan to include information necessary to care for the resident, initial goals, physician orders, dietary orders, therapy services, social services, and PASARR recommendations if applicable. 3. Charge Nurses will be educated on: " Provision of copy of the resident□s Baseline Care Plan " Documentation of provision of the Baseline Care Plan " Formulation of the Baseline Care Plan to include: " Information necessary to care for the resident " Initial goals " Physician orders	

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F 655	Continued From page 28 approximately 11:29 a.m. Resident #352 was asked if she received a written care plan summary, which include but not limited to her care plan goals, physician orders, therapy and diet orders and if so did anyone explain the summary to her. Resident #352 stated, "I have never received a summary of my medications." She said I really do not know what medications I am taking right now. An interview was conducted with the 7 a.m.-3 p.m. House Supervisor on 02/06/20 at approximately 12:30 p.m., who stated, "I only reviewed the initial care plan with (Resident #352)." She said when she reviewed the initial care with the residents; she never reviewed their medications, diet or their therapy goals. She said the Physician Order Sheet (POS), which contains their medications, diet and therapy is reviewed with them during their first care plan meeting which could be up to 21 days. The 7-3 House Supervisor stated, "If I'm told to do something, I will do it but I was never told what the 48-Hour Baseline Care Plan consisted of but I do now." A briefing was held with the Administrator on 02/06/20 at approximately 12:50 p.m. The facility did not present any further information about the findings. Definitions: -Pneumonia is an infection in one or both of the lungs (https://medlineplus.gov/druginfo/meds/a695002.html). 2. Resident #202 was admitted to the nursing facility on 1/23/20 with diagnoses that included traumatic subdural hematoma.	F 655	" Dietary orders " Therapy orders " Social services " PASSAR recommendations if applicable 4. A Registered Nurse will complete a random weekly review of provision of the Baseline Care Plan. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: March 7, 2020	

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The resident was not due for a Minimum Data Set (MDS) assessment. The admission nursing assessment dated 1/23/20 indicated Resident #202 was alert and oriented times 4 (person, place, time and situation).

On 2/5/20 an inquiry was made regarding completion of the 48 hour care plan. The 48 care plan presented dated 1/24/20 included only the initial goals of the patient and diagnoses.

The nurse's note dated 1/24/20 at 9:54 a.m. indicated Registered Nurse (RN) #2 gave the initial care plan to Resident #202.

On 2/6/20 at 12:30 p.m., an interview was conducted with the House Supervisor RN #2 who stated she was responsible to complete the baseline care plan otherwise referred to as the initial care plan. She said in her absence, the Assistant Director of Nursing (ADON) would complete the baseline/48 hour care plan. She stated, she and the ADON alternate weekends to ensure all the components of the baseline care plan were completed, presented and explained to the resident or resident representative. She stated the initial care plan did not include the medication list summary, dietary instructions or other services and treatments, but were included at the first care plan meeting at 21 days from admission. She said, "I was not told to include those specific pieces of the initial care plan. I cannot do what I haven't been told to do. If I was told to add those other components to the initial care plan, I would have."

An interview was conducted with Resident #202 at 1:00 p.m. He stated he was not given a list of his medications, diet or therapies

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The aforementioned issue was reviewed during the debriefing held on 2/6/20 at 3:15 p.m. with the Administrator, Director of Nursing (DON), Nurse Consultant, Diet Technician and Corporate Dietician. No further information was provided prior to survey exit.

3. Resident #97 was admitted to the nursing facility on 1/13/20 with diagnoses that included fractured cervical vertebrae and syncope.

The resident's Admission Minimum Data Set (MDS) assessment dated 1/20/20 assessed the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident's cognitive skills were intact for daily decision making.

On 2/5/20 an inquiry was made regarding completion of the 48 hour care plan. The 48 care plan presented dated 1/14/20 included only the initial goals of the patient and diagnoses.

On 2/6/20 at 12:30 p.m., an interview was conducted with the House Supervisor Registered Nurse (RN) #2 who stated she was responsible to complete the baseline care plan otherwise referred to as the initial care plan. She said in her absence, the Assistant Director of Nursing (ADON) would complete the baseline/48 hour care plan. She stated, she and the ADON alternate weekends to ensure all the components of the baseline care plan were completed, presented and explained to the resident or resident representative. She stated the initial care plan did not include the medication list summary, dietary instructions or other services and treatments, but were included at the first care

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plan meeting at 21 days from admission. She said, "I was not told to include those specific pieces of the initial care plan. I cannot do what I haven't been told to do. If I was told to add those other components to the initial care plan, I would have."

On 2/6/20 at 1:30 p.m., an interview was conducted with Resident #97. The resident's wife was also present during the interview. Both stated they remember a document that was given to them, but it did not include a medication list summary, diet or any therapies. Resident #97 stated he would have appreciated having a list of his medications because the physician was adjusting his blood pressure medications. He also stated having some explanation of his therapies would have also been helpful.

The aforementioned issue was reviewed during the debriefing held on 2/6/20 at 3:15 p.m. with the Administrator, Director of Nursing (DON), Nurse Consultant, Diet Technician and Corporate Dietician. No further information was provided prior to survey exit.

4. Resident #213 was admitted to the nursing facility on 1/31/20 with diagnoses that included spinal stenosis and post cervical surgical care.

The resident was not due for a Minimum Data Set (MDS) assessment. The admission nursing assessment dated 1/31/20 indicated Resident #213 was alert and oriented times 4 (person, place, time and situation).

On 2/5/20 an inquiry was made regarding completion of the 48 hour care plan. The 48 care plan presented dated 2/1/20 included only the

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initial goals of the patient and diagnoses.

On 2/6/20 at 12:30 p.m., an interview was conducted with the House Supervisor Registered Nurse (RN) #2 who stated she was responsible to complete the baseline care plan otherwise referred to as the initial care plan. She said in her absence, the Assistant Director of Nursing (ADON) would complete the baseline/48 hour care plan. She stated, she and the ADON alternate weekends to ensure all the components of the baseline care plan were completed, presented and explained to the resident or resident representative. She stated the initial care plan did not include the medication list summary, dietary instructions or other services and treatments, but were included at the first care plan meeting at 21 days from admission. She said, "I was not told to include those specific pieces of the initial care plan. I cannot do what I haven't been told to do. If I was told to add those other components to the initial care plan, I would have."

On 2/6/20 at 2:00 p.m., an interview was conducted with Resident #213. She stated she was not given an initial care plan that included a medication list summary, diet or therapies. She stated once she started physical therapy she was given good information from them.

The aforementioned issue was reviewed during the debriefing held on 2/6/20 at 3:15 p.m. with the Administrator, Director of Nursing (DON), Nurse Consultant, Diet Technician and Corporate Dietician. No further information was provided prior to survey exit.

The facility's policy and procedures titled

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F 655	Continued From page 33 Resident Assessment and Care planning dated 11/1/19 indicated that the computerized baseline care plan is initiated and activated within 48 hours. The care plan would provide the patient and representative(s) with a summary of the baseline care plan that includes, but is not limited to: The initial goals of the patient, a summary of the patient's medications list, the patient's dietary instructions and any services and treatments administered by the facility and personnel acting on behalf of the facility.	F 655		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Facility staff failed to follow professional standards of practice by failing to administer medications per physician's order; and failing to transcribe admission orders in a timely manner for 5 of 53 residents in the survey sample, Resident #252, #502, #253, #255 and #81. 1. For Resident #252, facility staff failed to transcribe transmission orders in a timely manner resulting in missed doses of medication; and failed to administer medications that were available in the facility stat box on 4/27/19. 2. For Resident #502, facility staff administered blood pressure medications outside the ordered parameters.	F 658	658 1. Residents #502 and #81 are receiving medications and treatments as ordered. Resident #252 discharged on 5/1/19. Resident #253 discharged on 4/14/19. Resident #255 discharged on 2/17/20. 2. Residents will have orders transcribed in a timely manner to ensure that medication is administered as ordered. Medications will be provided from the facility stat box when indicated. Blood pressure medications will be administered per ordered parameters. Daily weights will be obtained as ordered. Compression stockings will be applied as ordered. Treatments will be initiated in a timely	3/7/20

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F 658	Continued From page 34 3. For Resident #253, the facility staff failed to obtained daily weights per physician orders; and failed to follow physician orders for the administration of medications. 4. For Resident #255, the facility staff failed to apply the physician ordered compression stocking to the left lower extremity as ordered. 5. For Resident #81, the facility staff failed to ensure the resident received treatment to open areas on thighs in a timely manner. The findings included: 1. Resident #252 was admitted to the facility on 4/26/19 with diagnoses that included but were not limited to acute on chronic diastolic heart failure, end stage renal disease and dependence on dialysis. Resident #252's was in the facility for only five days and did not have a completed MDS (minimum data set) assessment. A head to toe assessment was completed at 2100 (9:00 p.m.) on 4/26/19. The admission assessment documented Resident #252 has being alert and oriented to person, place, and orientation. Review of Resident #252's April 2019 POS (physician order summary) revealed that his hospital discharge orders were not transcribed into the computer system until 4/27/19 (7 a.m. - 3 p.m. shift). Resident #252 missed all 7 a.m.-3 p.m. shift medications on 4/27/19. The following medications were not administered by the 7-3 shift nurse: 1) Allopurinol tablet 100 mg (milligrams) for gout. 2) Omperazole delayed release 20 mg	F 658	manner. 3. Nurses will be educated on: " Timely transcription of medication orders " Utilizing in-house STAT box for medications not available " Notifying MD if medication cannot be obtained in a timely manner " Administration and documentation of medication per ordered parameters " Documentation of daily weights as ordered " Administration and documentation of compression stockings as ordered " Identification of need for treatment and timely notification of MD/NP for treatment orders 4. A Registered Nurse will complete a random weekly review of residents with medication administration to ensure timely transcription, administration, and administration within ordered parameters , orders for weights, and orders for compression hose to ensure that the MD orders were followed. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: March 7, 2020	

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3) Plaquenil tablet 200 mg for discoid lupus*
4) Senna- S Tablet 8.6- 50 mg for constipation
5) Zoloft 100 mg for depression
6) Marinol Capsule 5 mg for appetite stimulant
7) Mucinex tablet extended release 12 hour 600 mg for cough
8) Phoslo Capsule 667 mg with meals for ESRD (end stage renal disease)
9) Calcitrol Capsule 0.5 MCG for ESRD.

Review of the facility STAT (emergency backup) box revealed that Omeprazole, Senna-S, and Zoloft were in the facility STAT box.

There was no reason documented in the clinical record why Resident #252's medications were not entered into the computer system until 4/27/19.

On 2/5/20 at 2:20 p.m., an interview was conducted with RN (Registered Nurse) #3, the RN supervisor who entered Resident #252's orders on 4/27/19. When asked the process for transcribing hospital discharge orders, RN #3 stated that the floor nurse assigned to the admitting resident was responsible for conducting the admission assessment and verifying physician orders. When asked the appropriate time frame for verifying orders; the RN supervisor stated that medications should be verified that same shift. RN#3 stated that if the nurse's shift ends prior to verifying medications; the next shift nurse should follow up. RN #3 stated that the nurse should first call the physician to verify orders and then enter them into the computer system. When asked if he could recall why Resident #252's orders were not entered into the computer system until the 7-3 shift on 4/27/19; RN #3 stated that he wasn't sure why the nurse did not enter the orders but stated that on 4/27/19

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he was alerted by the dietary department that a new resident was in a room but he did not have a dietary order. RN #3 stated that was when he checked the computer system and realized his orders were not entered in. RN #3 stated that he verified the medications that morning. RN #3 stated that he wasn't able to talk to the nurse who did Resident #252's admission to figure out why she did not verify orders. When asked the importance of verifying orders as soon as the resident was admitted, RN #3 stated it was important to verify orders immediately to prevent any missed doses of medication.

On 2/5/20 at 2:33 p.m., an interview was conducted with ASM (administrative staff member) #4, the nurse practitioner. When asked the process for verifying admission orders, ASM #4 stated that the nurses usually call her or the physician if she is not in the building and will review medications. ASM #4 stated that she will approve and or make changes at that time. ASM #4 stated that if the admission is after hours, the nurses can call an on-call service that will direct them to the on-call physician. ASM #4 could not remember that far back what had happened with Resident #252's admission. ASM #4 reviewed Resident #252's medications that were not administered on 4/27/19 and stated that one missed dose of the above medications would not result in any side effects or any major side effects. ASM #4 could not recall if she was notified about the above missed doses.

On 2/5/20 at 2/5/20 at 3:55 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #3, the nurse who worked on 4/26/19 and completed Resident #252's admission assessment. When asked the process of

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transcribing hospital orders; LPN #3 stated that when a resident is admitted to the facility, she will call the medical doctor, read all the hospital discharge orders and verify with physician whether to keep, add take away orders. LPN #3 stated that once orders were verified, she will enter them into the computer system. LPN #3 stated that the 11 p.m.-7 a.m. shift will also review orders to make sure all medications were entered. When asked the appropriate time frame for entering in hospital discharge orders, LPN #3 stated immediately to ensure the patient gets the medication at the next scheduled time. When asked if she could recall why she did not verify Resident #252's medications on 4/26/19 evening shift; LPN #3 stated that she was not sure, that she usually puts in orders for an admission. LPN #3 stated, "I wonder why I wouldn't put an order in." When asked the importance of verifying admission order immediately, LPN #3 stated that if she didn't put the orders in that evening shift, then the Resident would be able to get medications the next day. LPN #3 then stated that some medications might have been available in the STAT box and that the 7-3 shift nurse should have checked the STAT box for some of Resident #252's medications.

On 2/5/20 at 2:11 p.m. and 4:30 p.m.; and 2/6/19 at 9:56 a.m., an interview was attempted with the floor nurse who worked during the day shift on 4/27/19 with Resident #252. She could not be reached.

On 2/6/20 at 12:02 p.m., an interview was conducted with ASM #2, the DON (Director of Nursing). When asked the process for transcribing orders, ASM #2 stated that she would have expected the nurse on shift during the

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PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

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admission to verify physician orders immediately. ASM #2 stated that she would have also expected the 7-3 shift nurse on 4/27/19 to pull any medications that were in the emergency STAT box, if it was not yet up from pharmacy. ASM #2 was made aware of the above concerns. No further information was presented prior to exit.

2. For Resident #502, facility staff administered blood pressure medications outside the ordered parameters.

Resident #502 was admitted to the facility on 1/27/20 with diagnoses that included but were not limited to high blood pressure and chronic diastolic heart failure. Resident #502 did not have a completed admission MDS (minimum data set) assessment but was documented in an admission nursing note dated 1/27/19 as being "alert with some confusion."

Review of Resident #502's February 2020 MAR (medication administration record) revealed the following blood pressure medications:

1. "Lisinopril Tablet 5 mg (milligrams) Give one tablet by mouth one time a day for HTN (hypertension-high blood pressure) Hold for SBP (systolic blood pressure)* < (less than) 110." This order was initiated on 1/27/20.

2. "Norvasc Tablet Give 5 mg Give 1 (one) tablet by mouth two time a day for HTN Hold for SBP < 115." This order was initiated on 1/28/20.

Review of Resident #502's January 2020 MAR (medication administration record) revealed a check mark and nurses initials on 1/31/20 at 9:00 a.m., indicating she received Lisinopril and

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Norvasc when her blood pressure was recorded at "97 (systolic)/62."

Review of Resident #502's February 2020 MAR revealed a check mark and nurses initials on 2/1/20 at 9:00 a.m., indicating she received Norvasc when her blood pressure was recorded at "110/67."

Nursing notes could not be found regarding the above medication administrations.

On 2/5/20 at 2:33 p.m., an interview was conducted with ASM (administrative staff member) #4, the Nurse Practitioner. ASM #4 looked at Resident #502's MARs and stated that it appeared the blood pressure medications were given outside parameters on the above dates. ASM #4 stated that she did not recall giving an order to administer the blood pressure medications anyway.

On 2/5/20 at 4:45 p.m., an interview was conducted with RN (Registered Nurse) #2, the nursing supervisor. RN #2 stated the check marks on the MAR with the nurses initials meant that the medication was given. When asked if Resident #2 received the above blood pressure medications on 1/31/20 and 2/1/20, RN #2 looked at the MARs and stated that it looked like it was given. When asked if the order was followed, RN #2 stated that the order was not followed unless a separate nursing note was documented stating the physician was notified and was given an order to give.

On 2/5/20 at 4:47 p.m., and 2/6/20 at 10:57 a.m., attempts were made to interview LPN (Licensed Practical Nurse) #6, the nurse who administered

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Norvasc on 2/1/20, however she could not be reached for an interview.

On 2/6/20 at 11:08 a.m., an interview was attempted with the LPN who administered both Lisinopril and Norvasc on 1/3/20. She could not be reached.

On 2/6/20 at 3:26 p.m., ASM (administrative staff member) #1, the Administrator, ASM #2, and the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.

*Systolic blood pressure- "Blood pressure is the force of blood pushing against the walls of arteries. When the doctor measures your blood pressure, the results are given in two numbers. The first number, called systolic blood pressure, is the pressure caused by your heart contracting and pushing out blood. The second number, called diastolic blood pressure, is the pressure when your heart relaxes and fills with blood." This information was obtained from the National Institutes of Health. https://www.nia.nih.gov/health/high-blood-pressure.

3a. The facility staff failed to obtained daily weights per physician orders for Resident #253. Resident #253 was admitted to the facility on 03/22/19. Diagnosis for Resident #253 included but not limited to Congestive Heart Failure (CHF). The resident's Minimum Data Set (MDS) assessment was not due.

Review of Resident #253's Admission Assessment dated 03/22/19 included the following: orientation neurological was coded with

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no memory impairment. The assessment also included the following under Activities of Daily Living/Functional devices was coded: independent with eating and bed mobility and supervision with toilet use and transfers.

Review of Physician Progress note dated 03/29/19 included the following documentation: Start daily weights.

Review of Resident's #253 Medication Administration Record (MAR) for April 2019 indicated the following order:
-Weight patient daily approximately the same time each day, notify provider for weight gain greater than or equal 3 pounds in one day or 5 pounds in a week.

Review of Resident's #253 Treatment Administration Record (TAR) for April 2019 indicated the following missing weights: 04/02, 04/03, 04/05, 04/07, 04/09, 04/10 and 04/13/19.

An interview was conducted with the Director of Nursing (DON) on 02/06/20 at approximately 11:00 a.m. The DON said she expect for nurses to obtained daily weights as ordered by the physician. The DON was asked, "What is the purpose of daily weight" she replied, "To monitor for edema and fluid in the lungs and if a weight gain is present, it could indicate as sign of CHF."

Definitions:
-Heart failure is a condition in which the heart cannot pump enough blood to meet the body's needs (https://medlineplus.gov/druginfo/meds/a695002.html).

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3b. The facility staff failed to follow physician orders for the administration of medications for Resident #253.

Review of Resident's #253 Medication Administration Record for April 2019 indicated the following medication orders:
1. Anoro Ellipa Aerosol Powder Breath - 1 puff inhale orally one time a day at 9:00 a.m., for Chronic Obstructive Pulmonary Disease (COPD).
2. Lasix 40 mg - give 1 tablet by mouth daily at 9:00 a.m., for edema.
3. Potassium Extended Release (ER) - give 1 tablet by mouth daily at 9:00 a.m., for hypokalemia.

Review of Resident #253 Medication Administration Audit Record for April 2019 revealed the following medication administration times:
1. Anoro Ellipa Aerosol Powder Breath was document as administered at the following times for the 9 a.m. dose: on 04/02/19 @ 12:13 p.m.
2. Lasix was documented as administered at the following times for the 9 a.m. dose: on 04/02/19 @ 12:15 p.m.
3. Potassium was documented as administered at the following times for the 9 a.m. dose: on 04/02/19 @ 12:20 p.m.

On 02/06/20 at approximately 2:15 p.m., an interview was conducted with Director of Nursing (DON). The DON was asked, "When a medication is ordered to be administered at 9:00 a.m., when can the medication be administered?" the DON replied, "There is a hour window from the time the medication is scheduled." The DON said 9:00 a.m., medications can be given as early as 8:00 a.m., but not later than 10:00 a.m.

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A briefing was held with the Administrator on 02/06/20 at approximately 12:50 p.m. The facility did not present any further information about the findings.

Definitions:
-Once-daily ANORO is a prescription medicine used long term to treat chronic obstructive pulmonary disease (COPD), including chronic bronchitis, emphysema, or both, for better breathing and to reduce the number of flare-ups. ANORO is not for asthma. (anoro.com)
-Lasix is used alone or in combination with other medications to treat high blood pressure. Lasix is used to treat edema (fluid retention; excess fluid held in body tissues) caused by various medical problems, including heart, kidney, and liver disease (medlineplus.gov).
4. For Resident #255, the physician ordered compression stocking for the left lower extremity was not applied as ordered, in addition the staff had been signing off the Treatment Administration Record for the compression stocking as applied and removed.

Resident #255 was admitted to the facility on 1/23/20 with diagnoses to include but not limited to diabetes, chronic pain, and acquired right leg above the knee amputation. An admission MDS had not been completed prior to survey. The resident was alert and orientated to person, place and time.

The physician progress noted dated 2/3/20 read, in part: "...alert, responsive and appears to be in no acute distress. Patient had been concerned on 02/02/2020 that his left foot was edematous and his shoe was not fitting. Physical exam:

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Edema/varicosities of extremities- Trace nonpitting left pedal edema. Diagnosis, Assessment, Plan-Peripheral edema- Compression stocking apply to left lower extremity QAM (every morning) & remove QPM (every evening)."

The physician orders dated 2/4/20 instructed the staff to apply a compression stocking to the resident's left lower extremity (LLE) every morning and remove every evening for the diagnosis and treatment of edema (fluid retention or swelling).

The resident was observed on 2/4/20 at 4:50 p.m., and on 2/5/20 at 2:22 p.m., in bed without a compression stocking to the left lower extremity. At 3:24 p.m., the resident was awake sitting on the edge of bed, he stated the staff have not offered or provided a compression stocking as ordered, he stated he would accept it if offered.

On 2/6/20 at 11:15 a.m., the resident was observed in bed. The compression stocking was not observed on the LLE. The resident was asked if the staff had offered the stocking and he stated, "No, no one has offered one".

On 2/6/20 at 11:20 a.m., the Licensed Practical Nurse (LPN #7) assigned to care for the resident was interviewed. She was asked about the compression stocking for Resident #255. She stated, "I know he didn't have them on yesterday". When showed the TAR documentation that she had initialed on 2/4/20 and 2/5/20 as having applied the compression stocking LPN #7 said, "I must have just clicked on it." She further stated, "I'll make sure he get's one on today." When asked if the facility had the compression stocking

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available she stated, "Yes."

The above findings was shared with the Director of Nursing (DON) and the Nurse Consultant on 2/6/20 at approximately 11: 45 a.m. The DON stated, "If you sign for it, you do it". No additional information was provided prior to exit.

5. For Resident #81, the facility staff failed to ensure resident received treatment to open areas on thighs in a timely manner. Resident #81 was initially admitted to the facility on 01/04/2020. Diagnosis included but were not limited to Coronary Artery Disease and Heart Failure. Resident #81's Admission Minimum Data Set (MDS an assessment Protocol) with an Assessment Reference Date of 01/11/2020 was coded with a BIMS (Brief Interview for Mental Status) score of 14 indicating no cognitive impairment.

On 02/04/2020 at 2:04 p.m., during initial tour of the facility, an interview was conducted with Resident #81's wife and she stated, "He has skin breakdown from lying in his urine, on his buttocks and between his legs in the front."

Resident #81's Clinical Record was reviewed on 02/05/2020 and revealed the following:

Review of Minimum Data Set with an Assessment Reference Date of 01/11/2020 revealed the following: "Section H0300 - Urinary Continence - was coded as Frequently Incontinent"; "Section H0400 - Bowel Continence - was coded as Always Incontinent."

Review of Progress Note dated 02/05/2020 revealed and is documented in part, as follows: "Type: Skin/Wound Note Effective Date:

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F 658	Continued From page 46 02/05/2020 08:49:00 Created By: Licensed Practical Nurse (LPN) #1 Created Date: 02/05/2020 09:54:55 Note Text: Skin Assessment completed. Findings: Turgor: Good Elasticity Skin Color: Normal for ethnic group Temperature: Warm (normal) Moisture: Normal Condition: Normal New Wounds: 0 " On 02/05/2020 at approximately 2:00 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #1, when asked if Resident #81 had any open areas or a rash on his buttocks or thighs, LPN #1 stated, "No." On 02/05/2020 at approximately 4:00 p.m., an interview was conducted with Registered Nurse (RN) #1, when asked if Resident #81 had any open areas or a rash on his buttocks or thighs, RN #1 stated, "No." Requested to be notified the next time staff performed incontinence care. On 02/05/2020 at approximately 5:30 p.m., RN #1 reported that Resident #81 was sitting up in his wheelchair and did not want to be changed at this time; he wanted to eat dinner. Requested to be present during incontinence care the morning of 02/06/2020. On 02/06/2020 at approximately 8:55 a.m., accompanied RN #1 at Resident #81's bedside. The resident was lying in bed. RN #1 unfastened the residents adult brief and observed multiple small open areas on skin of both inner upper thighs at scrotum area. Observed white cream on open areas. No open areas noted on buttocks. On 02/06/2020 at approximately 9:10 a.m., an interview was conducted with RN #1, when asked	F 658		

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what was the white cream on Resident #81's open areas, RN #1 stated, "Dimethicone." When asked when was the medication ordered, RN #1 stated, "It was started on 02/05/2020 after I looked at him." RN #1 stated, "The staff put an alert in on 02/04/2020 at 6:59 a.m." Copy of alert was requested. Received copy of Clinical Alerts Listing Report. Review of report revealed the following: "Effective Date: 02/04/2020 06:59 Description: Change in skin color or condition Cleared by: RN #1 Cleared Date: 02/06/2020." RN #1 stated, "I usually pull the reports every morning, I must have already pulled the reports before this alert showed up." When asked if she would have pulled the report on 02/05/2020, RN #1 stated, "No, I was not here in the morning on 02/05 but someone would have pulled it." RN #1 stated, "I looked at him yesterday evening (02/05/2020) and saw the open areas and obtained the order for Dimethicone." When asked if a treatment should have already been started for Resident #81, RN #1 stated, "Yes."

Resident #81's Clinical Record was reviewed on 02/06/2020 at approximately 9:30 a.m. and revealed the following:

Review of PCC Skin and Wound - Total Body Assessment dated 01/04/2020 6:58 p.m. revealed the following: "New Wounds - 0."
Review of PCC Skin and Wound - Total Body Assessment dated 01/11/2020 6:58 p.m. revealed the following: "New Wounds - 0."
Review of PCC Skin and Wound - Total Body Assessment dated 01/15/2020 8:49 a.m. revealed the following: "New Wounds - 0."
Review of PCC Skin and Wound - Total Body Assessment dated 01/22/2020 8:49 a.m. revealed the following: "New Wounds - 0."

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Review of PCC Skin and Wound - Total Body Assessment dated 01/29/2020 8:49 a.m. revealed the following: "New Wounds - 0."
Review of PCC Skin and Wound - Total Body Assessment dated 02/05/2020 8:49 a.m. revealed the following: "New Wounds - 0."
Review of PCC Skin and Wound - Total Body Assessment dated 02/05/2020 8:41 p.m. revealed the following: "New Wounds - 3."

Review of Progress Note dated 02/05/2020 revealed and is documented in part, as follows: "Effective Date: 02/05/2020 20:41 Type: Skin/wound Note Skin Assessment completed. Findings: Turgor: Good Elasticity Skin Color: Normal for ethnic group Temperature: Warm (normal) Moisture: Normal Condition: Normal New Wounds: 3. Author: RN #1."

Review of Progress Note dated 02/05/2020 revealed and is documented in part, as follows: "Effective Date: 02/05/2020 20:57 Type: Health Status Note Nurse Practitioner notified of open areas to inner/posterior thighs and order obtained to apply Dimethicone lotion to inner/posterior thighs QS (Every Shift) and PRN (As Needed). RP (Responsible Party), self, notified. Author: RN #1.

Review of Medication Administration Record for period of 02/01/2020 through 02/29/2020 revealed the following: "Dimethicone Lotion Apply to inner/posterior thighs topically every shift for wound care Order Date - 02/05/2020 D/C (Discontinued) Date - 02/05/2020": "Dimethicone Lotion Apply to inner/posterior thighs topically every shift for wound care cleanse open areas with DWC, pat dry, apply dimethicon lotion Order Date - 02/06/2020."

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F 658	Continued From page 49 On 02/06/2020 at 1:33 p.m., an interview was conducted with the Director of Nursing (DON) and discussed the above. When asked what her expectations are of the nurses, the DON stated, "If there is a skin alert on the dashboard the nurses should follow up and see the wound, speak with the CNA (Certified Nursing Assistant) and follow up with the physician." The Administrator, Director of Nursing, Corporate Nurse Consultant, Corporate Dietician and Corporate Technician was informed of the finding at the pre-exit meeting on 02/06/2020 at approximately 4:30 p.m. No further information was provided. Complaint deficiency.	F 658		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		3/7/20

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F 755	Continued From page 50 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to provide pharmaceutical services to meet the needs of 1 of 53 residents in the survey sample, Resident #256. The facility failed to provide the anti-anxiety medication clorazepate dipotassium 7.5 milligram (mg) tablet three times a day for the first three days following admission. The findings included: Resident #256 was admitted to the facility on 1/16/2020 with diagnoses to include, but not limited to anxiety disorder. The current MDS (Minimum Data Set) an Admission with an assessment reference date of 1/23/20 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was intact. The resident was coded as having received an anti-anxiety medication for 4 days during the last 7 days. The admission physician orders dated 1/16/20	F 755	755 1. Resident #256 is receiving Clorazepate dipotassium as ordered. 2. The Admissions staff will request a written prescription for controlled medications from the hospital at time of admission. If a medication is not available as ordered, the physician will be notified for a change in orders. 3. Nurses will be educated on: " Timely request of written prescription of controlled medications if not provided at time of admission " Utilizing in-house STAT box " Notifying MD when medication is not available 4. A Registered Nurse will complete a random weekly review of medication administration to ensure that medications have been administered as ordered. 5. Issues noted during the random weekly review will be presented to the	

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F 755	Continued From page 51 instructed the staff to administer the anti-anxiety medication clorazepate dipotassium 7.5 milligram (mg) tablet three times a day. The medication was scheduled to be administered daily at 9 a.m., 2 p.m., and 9 p.m. The person-centered plan of care evidenced a focus area identified as the resident was on anti-anxiety medications dated 1/28/20. The goal was that the resident would be free of psychotropic drug related complications. One of the interventions was to monitor for side effects and effectiveness. The Medication Administration Record (MAR) for January 2020 evidenced the staff initialed entries for 1/17/20, 1/18/20 and 1/19/20 for the clorazepate dipotassium 7.5 milligram (mg) tablet three times a day as not administered, a total of nine doses. Clorazepate dipotassium is a scheduled II controlled substance. Further investigation evidenced a nursing progress noted dated 1/19/20 that read: " This writer called pharmacy to inquire about script for the medication clorazepate dipotassium. Pharmacy personnel stated the script for the medication was not received. Called on call regarding this situation. (resident name) shows not signs or c/o (complaint) anxiety at this time." The above findings was shared with the Director of Nursing (DON) on 2/5/20 at 10:20 a.m.. She stated the resident came from the hospital without a hard script for the clorazepate dipotassium, that is what caused the delay in obtaining the medication from the pharmacy. She further stated this drug is not maintained in the facility pharmacy stat box.	F 755	Quality Assurance Committee for review and recommendation. 6. Completion date: March 7, 2020	

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F 755	Continued From page 52 The pharmacy Proof of Delivery Shipment Summary date 1/19/20 evidenced an initial quantity of 12 tablets of clorazepate dipotassium was filled and delivered on 1/19/20 at 10:25 p.m. The facility Pharmacy Policy and Procedure titled 4.2 New Orders for Schedule II Controlled Substances revised 01/01/13 read, in part: 1. New orders for Schedule II controlled substances require a complete written prescription prior to dispensing, unless there is an "Emergency Situation". Where permitted under Applicable Law, Facility staff may fax Schedule II prescriptions for long term care residents, terminally ill residents, or where the medication is used for direct infusion (e.g., morphine drip). No additional information was provided prior to exit.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		3/7/20

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F 761	Continued From page 53 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility document review the facility staff failed to label 4 open multi-dose vials of Thiamine with the opened date potentially affected any resident with physician ordered Thiamine. The findings included: On 2/6/20 at 10:36 A.M. The Unit 100 medication room was inspected with Unit Manager Registered Nurse (RN) #4. While inspecting the refrigerator, 4 opened, undated 2 ml. (milliliter) multi-dose vials of Thiamine were observed. Unit Manager RN #4 was asked about the 4 open vials of Thiamine and stated, "The vials should have been dated when they were opened I'm not sure how long they are good for I will call the pharmacy." On 02/06/20 at 12:38 PM an interview was conducted with the Director of Nursing regarding the 4 open multi-dose vials of Thiamine and asked what are her expectations for the nursing staff when they open a multi-dose vial. The Director of Nursing stated, "I expect them to date all medications once they open them."	F 761	761 1. The outdated multi-dose vials (4) of Thiamine were discarded on 2/6/20. 2. Medications are properly stored with labeling and dating when opened. 3. Nurses will be educated on: " Labeling of medications " Dating of medication when opened " Monitoring of labels and dating when opened 4. A Registered Nurse will complete a random weekly review of the medication storage areas to ensure that medications are labeled and dated when opened. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: March 7, 2020	

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F 761	Continued From page 54 On 02/06/20 1:15 PM Unit Manager RN #4 stated, "The pharmacist just called and said the vials are only good for 28 days after being opened." On 2/6/20 at 2:15 P.M. the facility Nurse Consultant stated, "The facility follows the pharmacy policy for Medication Storage and it states multi-dose vials are only good for 28 days." On 2/6/20 at 3:30 P.M. a pre-exit debriefing was conducted with the Administer, the Director of Nursing and the Nurse Consultant were the above was shared. Prior to exit no further information was shared.	F 761		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's	F 803		3/7/20

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F 803	Continued From page 55 dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that facility staff failed meet the nutritional preferences and follow the menu for 2 of 53 residents in the survey sample, Residents #93 and #66. The findings included: 1. Resident #93 was admitted to the facility on 1/8/20 with diagnoses that included but were not limited to wedge compression fracture of second lumbar vertebrae, and repeated falls. Resident #93's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 1/15/2020. Resident #93 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. On 2/4/20 at 12:13 p.m., an interview was conducted with Resident #93. Resident #93 stated that she never knew what she was getting on her meal tray because most of the time the food items never matched the menu or she would never receive a menu. Resident #93 stated that she always ate lunch up in her bed due to pain from her spinal fracture. Review of Resident #93's February 2020 POS	F 803	803 1. Resident #93 was discharged on 2/5/20. Resident #66 was discharged on 2/12/20. 2. Menus will be served as posted and per resident□s choice as listed on the menu tray ticket. 3. Training has been completed with Dietary staff to serve all items as listed on the menu and menu tray ticket. 4. A random weekly review will be completed to ensure that menus are served as posted and per resident preference as listed on the menu tray ticket. 5. Results of the monitoring will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: March 7, 2020	

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(physician order summary) revealed the following dietary order: "Regular Diet- Regular texture, Regular liquids consistency."

On 2/4/20 at 12:40 p.m., the tray line for lunch was observed in the kitchenette area of unit two. The following was being offered for lunch:

Chicken Salad Plate - Chef's choice
Pot Roast - Main Meal
Fried Potatoes/Onions
Mashed Potatoes
Broccoli
Pecan Pie

On 2/4/20 at 12:57 p.m., after serving the residents in the dining room, the dietary cook began preparing meal trays for the residents in their rooms. At approximately 1:00 p.m., the broccoli was observed to be gone. The dietary cook asked a dietary aide to grab more broccoli from the kitchen. The dietary cook continued making up meal trays and placed at least four trays into the cart without broccoli. At 1:13 p.m., the broccoli arrived to unit two from the kitchen and was placed on the steam table. The broccoli was not added to the four trays that had already went out on the hallway.

On 2/4/20 at approximately 12:28 p.m., an observation was made of Resident #93's plate. She only had a scoop of chicken salad and some fried potatoes with onions on her plate. When asked if she received everything that she had ordered, Resident #93 stated that she was not sure, that she did not receive a menu the day before to select food items. Resident #93 did not have the pecan pie or broccoli on her plate. Resident #93 stated that she also did not receive

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any condiments for her food or sugar for her iced tea. Resident #93 did not have a meal ticket beside her tray.

On 2/4/20 at 1:39 p.m. an interview was conducted with OSM #3 (the dietary cook). When asked the process for Residents choosing food items from the menus, OSM #3 stated that residents will receive a menu or ticket the day before their meals for them to select food choices. When asked who delivers and picks up these tickets, OSM #3 stated that he was not sure. When asked if residents ever get missed or meal tickets ever get lost, OSM # 3 stated that sometimes meal tickets will accidentally be thrown away. When asked the process if he does not receive a meal ticket from a resident prior to that meal; OSM #3 stated that he would just serve whatever was in bold type on the menu. OSM #3 stated that the bolded food items were the "Chef's Choice." When asked if anyone (staff) would go down to confirm with the resident their food choices if they did not receive a ticket from the resident, OSM #3 stated, "No." When asked what had happened to the broccoli during lunch, OSM #3 stated that he ran out at the steam table and had to ask the kitchen to make more. When asked if every resident that was supposed to receive broccoli, had broccoli on their plates, OSM #3 stated, "No." OSM #3 stated that the broccoli arrived to the unit after he sent the trays to the hall. OSM #3 stated that the residents who did not receive the broccoli will not receive it unless they request it.

On 2/5/20 at approximately 9:00 a.m., Resident #93's meal ticket for lunch on 2/4/20 was requested from the kitchen. The following was documented on Resident #93's meal ticket for

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2/4/19: "Chef's choice Meal." This was bolded indicating that she should have received the chicken salad.

On 2/5/20 at 9:59 a.m., further interview was conducted with Resident #93. Resident #93 was shown the menu for lunch on 2/4/19. Resident #93 stated that if she knew the kitchen was serving pecan pie and broccoli, she would have chose those items to be on her plate. Resident #93 stated that she liked both food items.

On 2/6/20 at 9:48 a.m., further interview was conducted with the dietary cook. When asked if a resident selects the
"Chef's Choice" meal if that should also include the pecan pie and broccoli; OSM #3 stated that it should. When asked why Resident #93 did not receive the pecan pie as well as the broccoli on 2/4/20; OSM #3 stated that she should have. When asked if the unit (unit two) ran out of these items, OSM #3 stated that he only ran out of the broccoli. OSM #3 was told that Resident #93 was never offered a menu the day before to pick out her meal choices. OSM #3 stated that if he didn't have a meal ticket for Resident #93, or if the ticket was blank, that he should have confirmed with Resident #93 her meal choices.

On 2/6/20 at 11:33 a.m., an interview was conducted with the Dietary Manager. When asked the process for residents selecting their meals; OSM #5 stated that a ticket is delivered to their room by dietary staff; residents will select their food options for the next day for each meal, and then either dietary or nursing staff will collect the tickets and bring them to the kitchen. When asked the process if dietary does not have a meal ticket for a resident prior to that meal, OSM #5

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stated that he expects his dietary staff to take a meal ticket to the resident's room and have them fill it out. OSM #5 stated that if the resident does not want to fill out the meal ticket, his staff should be serving the bolded items on the menu (Chef's Choice). When asked if the Chef's Choice still included the pecan pie and broccoli, OSM #5 stated that it did. OSM #5 stated that the only difference was that the Residents who selected "Chef's Choice" should have received the chicken salad plate rather than the pot roast. OSM #5 was told about Resident #93 not receiving the broccoli or pecan pie. OSM #5 stated that these items could have possibly been a dislike of Resident #93. OSM #5 looked at Resident #93's ticket and stated that he didn't see these items as a dislike. OSM #5 was also told about the unit running out of broccoli and the four trays going out the residents prior to broccoli coming up from the kitchen. OSM #5 stated that residents shouldn't have to request for their broccoli or any other food items that were supposed to make it on their tray. When asked if the units or kitchen frequently run out of food items, OSM #5 stated that the units can run out, but that the cook should ask a dietary aide to grab more food from the other units or the kitchen. OSM #5 stated that most of the time the staff do not want to be bothered to check the other units or kitchen.

On 2/6/20 at 3:26 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.

2. Resident #66 was admitted to the facility on 12/29/19 with diagnoses that included but were

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not limited to wedge compression fracture of first lumbar vertebra. Resident #66's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 1/5/20. Resident #66 was coded as being moderately impaired in cognitive function scoring 11 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

On 2/4/20 at 12:30 p.m., an interview was conducted with Resident #66 and a family member (husband). Resident #66's husband stated that his wife never received what she ordered from the menu. The husband stated that every night someone will pass out a meal ticket for the following day and he will select food items for his wife. The family member stated that they almost never get what they order. Resident #66 stated that most of the time the staff will say they run out of food items and then bring it later anyway. Resident #66's husband stated it was because he would "raise hell" and someone from the kitchen would finally bring what staff claimed they ran out of.

Review of Resident #66's February 2020 POS (physician order summary) revealed the following dietary order: "Heart Healthy Diet- Regular texture, Regular Liquids Consistency."

On 2/4/20 at 12:40 p.m., the tray line for lunch was observed in the kitchenette area of unit two. The following was being offered for lunch:

Chicken Salad Plate - Chef's choice
Pot Roast - Main Meal
Fried Potatoes/Onions
Mashed Potatoes
Broccoli

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F 803	Continued From page 61 Pecan Pie On 2/4/20 at 12:57 p.m., after serving the residents in the dining room, the dietary cook began preparing meal trays for the residents in their rooms. At approximately 1:00 p.m., the broccoli was observed to be gone. The dietary cook asked a dietary aide to grab more broccoli from the kitchen. The dietary cook continued making up meal trays and placed at least four trays into the cart without broccoli. At 1:13 p.m., the broccoli arrived to unit two from the kitchen and was placed on the steam table. The broccoli was not added to the four trays that had already went out on the hallway. On 2/4/20 at approximately 1:30 p.m., Resident #66's husband brought his wife's tray over to this writer. Resident #66's husband stated that they did not get what they had ordered. The husband stated they ordered a bunch of different food items the night before but he could not remember what they had ordered. An observation was made of Resident #66's tray. Resident #66 received pot roast and the fried onions with potatoes. Resident #66 did not receive pecan pie or broccoli. On 2/4/20 at 1:39 p.m. an interview was conducted with OSM #3 (the dietary cook). When asked the process for Residents choosing food items from the menus, OSM #3 stated that residents will receive a menu or ticket the day before their meals for them to select food choices. When asked who delivers and picks up these tickets, OSM #3 stated that he was not sure. When asked if residents ever get missed or meal tickets ever get lost, OSM #3 stated that sometimes meal tickets will accidentally be thrown away. When asked the process if he does	F 803		

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not receive a meal ticket from a resident prior to that meal; OSM #3 stated that he would just serve whatever was in bold type on the menu. OSM #3 stated that the bolded food items were the "Chef's Choice." When asked if anyone (staff) would go down to confirm with the resident their food choices if they did not receive a ticket from the resident, OSM #3 stated, "No." When asked what had happened to the broccoli during lunch, OSM #3 stated that he ran out at the steam table and had to ask the kitchen to make more. When asked if every resident that was supposed to receive broccoli, had broccoli on their plates, OSM #3 stated, "No." OSM # stated that the broccoli arrived to the unit after he sent the trays to the hall. OSM #3 stated that the residents who did not receive the broccoli will not receive it unless they request it.

On 2/4/20 at 2:50 p.m. further interview was conducted with Resident #66. When asked if they received an alternate meal, Resident #66 stated that the housekeeper got her a chicken salad plate from the kitchen.

On 2/5/20 at approximately 9:00 a.m., Resident #66's meal ticket for lunch on 2/4/20 was requested from the kitchen. The following was documented on Resident #66's meal ticket for 2/4/19: "Chef's choice Meal." This was bolded indicating that she should have received the chicken salad instead of the post roast initially.

On 2/6/20 at 9:48 a.m., further interview was conducted with the dietary cook. When asked if a resident selects the
"Chef's Choice" meal if that should also include the pecan pie and broccoli; OSM #3 stated that it should. When asked why Resident #66 did not

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receive the pecan pie as well as the broccoli on 2/4/20; OSM #3 stated that she should have. When asked if the unit (unit two) ran out of these items, OSM #3 stated that he only ran out of the broccoli.

On 2/6/20 at 11:33 a.m., an interview was conducted with the Dietary Manager. When asked the process for residents selecting their meals; OSM #5 stated that a ticket is delivered to their room by dietary staff; residents will select their food options for the next day for each meal, and then either dietary or nursing staff will collect the tickets and bring them to the kitchen. When asked the process if dietary does not have a meal ticket for a resident prior to that meal, OSM #5 stated that he expects his dietary staff to take a meal ticket to the resident's room and have them fill it out. OSM #5 stated that if the resident does not want to fill out the meal ticket, his staff should be serving the bolded items on the menu (Chef's Choice). When asked if the Chef's Choice still included the pecan pie and broccoli, OSM #5 stated that it did. OSM #5 stated that the only difference was that the Residents who selected "Chef's Choice" should have received the chicken salad plate rather than the pot roast. OSM #5 was told about Resident #66 not receiving the broccoli or pecan pie and being served the pot roast when "Chef's Choice" was selected. OSM #5 stated that these items (pecan pie, broccoli) may have possibly been a dislike of Resident #66. OSM #5 looked at Resident #66's ticket and stated that he didn't see these items as a dislike. OSM #5 was also told about the unit running out of broccoli and the four trays going out the residents prior to broccoli coming up from the kitchen. OSM #5 stated that residents shouldn't have to request for their broccoli or any other food items that were

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F 803	Continued From page 64 supposed to make it on their tray. When asked if the units or kitchen frequently run out of food items, OSM #5 stated that the units can run out, but that the cook should ask a dietary aide to grab more food from the other units or the kitchen. OSM #5 stated that most of the time the staff do not want to be bothered to check the other units or kitchen. On 2/6/20 at 3:26 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.	F 803		
F 804 SS=D	. Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and facility document review, it was	F 804	804	3/7/20

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F 804	Continued From page 65 determined that facility staff failed to serve food at a palatable temperature and taste for 2 (Resident # 93 and #66) of 53 residents in the survey sample, one of four nursing units, Unit 2. The findings included: On 2/4/20 at 12:13 p.m., an interview was conducted with Resident #93. Resident #93 stated that her food was always cold for every meal and that staff had to warm up her meals every time. Resident #93 stated that she always ate in her room and wasn't sure why her food was always cold. Resident #93 stated that lunch time was at 12:45 p.m. and she always received her tray at 1:30 p.m. On 2/4/20 at 12:30 p.m., an interview was conducted with Resident #66 and a family member. Resident #66's family member stated, "The food sucks, it is always cold. Sometimes it is as cold as water." Resident #66's family member was pointing to a cup of ice water while saying this comment. This family member had also stated that they did not receive their meals until after 1:30 p.m. On 2/4/20 at 12:40 p.m., temperature of the food on the steam table was conducted with OSM (other staff member) #3, the dietary cook. The following temperatures were recorded in degrees Fahrenheit: Mashed potatoes- 157 degrees Pot roast- 197 Fried Potatoes with Onions- 152 Steamed broccoli- 150.0 Soup- 177.0	F 804	1. Resident #93 was discharged on 2/5/20. Resident #66 was discharged on 2/12/20. 2. Food served in the dining area and resident rooms will be prepared and maintained in such manner as to ensure that food is served at proper temperature for safety and is palatable in temperature and taste. 3. Food will be served in an insulated meal cart for residents eating in their rooms. Dietary and Nursing staff will be educated on use of the insulated meal carts. 4. A random weekly test tray of food to be served in a resident room will be completed to ensure that the temperature is palatable. 5. Results of the monitoring will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: March 7, 2020	

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On 2/4/20 at 12:41 p.m., one dietary cook was behind the steam table preparing plates while 3 nursing staff assisted passing out plates to residents in the dining area.

On 2/4/20 at 12:43 p.m. the first person in the dining area was served her meal. A fourth staff member also started helping in the dining room at this time.

On 2/4/20 at 12:50 p.m., a resident in the dining room told this writer that the food was usually cold, even in the dining room, but that his lunch was fine that afternoon.

On 2/4/20 at 12:57 p.m., two resident trays were prepared and put into a metal cart. The plates on the resident trays did not have metal warmers underneath. The metal cart doors remained open while OSM #3 prepared the rest of the trays for the residents dining in their rooms.

On 2/4/20 at 1:13 p.m., the last tray was prepared. This writer asked for a test tray to be placed on the cart.

On 2/4/20 at 1:16 p.m. the first tray was served on the hall.

On 2/4/20 at 1:35 p.m., the last resident was served and the test tray was conducted. The following temperatures were recorded:

Mashed Potatoes- 119
Fried Potatoes with Onions: 108
Pot Roast- 110

The broccoli was not an item provided on the test tray. The food was not palatable for temperature

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or taste. The food tasted bland.

On 2/4/20 at 1:39 p.m., an interview was conducted with OSM #3, the dietary cook. When asked if he had ever tasted his food before, OSM #3 stated that he has in the past but usually right off the steam table. When asked if he ever received frequent complaints about the food being cold, OSM #3 stated that he occasionally received complaints. When asked why his food was cold, OSM #3 stated that he wasn't sure, but that it could be that he didn't have plate warmers.

On 2/6/20 at 11:33 a.m., an interview was conducted with OSM #5 , the main dietary manager. When asked the process on how to maintain food temperatures from the steam table to the nursing units (resident rooms), OSM #5 stated that the correct way would be to get a palate heater base system that would keep the plate warm. OSM #5 stated that he was just approved for this item in the facility's budget and will be ordering the thermal bases. OSM 5 also stated that they did not have thermal delivery carts to keep the food warm. OSM #5 also stated that the unit should have been preparing a tray and then running it to that resident's room, rather than letting it sit on the cart. OSM #5 was made aware of the following observations and that the test tray was cold to taste 22 minutes from it coming off the steam table. When asked the appropriate temperatures for hot food to be held on the steam table, OSM #5 stated that appropriate food items should be held from 135 to 180 degrees Fahrenheit.

On 2/6/2020 at 3:26 p.m., ASM #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above

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F 804	Continued From page 68 concerns. Facility policy titled, "Dining Services and Procedures," documents in part, the following: "Foods will be prepared and served at proper temperatures to ensure food safety and palatability."	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, facility documentation review, and staff interviews, the facility staff in the kitchen failed to ensure that food was properly stored and labeled, and that, coffee cups were cleaned and stored in a sanitary manner potentially affecting most residents in the facility.	F 812	812 1. Food is currently stored and labeled properly and coffee cups are cleaned and stored in a sanitary manner. 2. An observation of food was completed to ensure that food is properly	3/7/20

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F 812	Continued From page 69 The findings included: 1a. During an initial inspection of the facility kitchen occurring on 02/04/2020 at approximately 11:37 a.m., the following observations were made: 1. Stored frozen personal pizza with no use by dates. 2. Stored frozen raw stuffed chicken breasts in the freezer with a use by date of 1/16/2020. 3. Stored frozen fish fillets with no used by date. 4. Stored opened barbeque sauce in the reach-in refrigerator with no use by date. 5. Stored hamburger patties with use by date of 01/16/2020 in the reach-in refrigerator. 6. Stored teriyaki in the reach-in refrigerator with no used-by date. 7. Stored an opened jar of mayonnaise with no use by dates. 8. Stored blocks of ham (uncut), covered and in a pan with no use by date. During an interview regarding food storage on 2/6/2020 at approximately 2:00 p.m. with the Dietary Manager, he stated, "Once foods are opened, they should be discarded in 3 days." Facility provided policy dated 09/06/2019 Refrigerated and Frozen Food: Foods stored in the refrigerator or freezer will be stored in a manner which maintains the food so that it is safe to eat, and retains optimal nutrient content and aesthetic quality. 1. All refrigerated and frozen foods shall be stored in sealed/closed containers no less than six (6) inches off the floor. 2. All refrigerated and frozen food containers will	F 812	stored and labeled and that utensils are cleaned and stored under sanitary conditions. 3. Dining Service staff will be educated on proper storage, labeling and cleaning of food and utensils. 4. A random weekly review of food storage and cleanliness will be completed by the Dietary Service Manager to ensure that food is properly stored and labeled and that utensils are cleaned and stored under sanitary conditions. 5. Results of the monitoring will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: March 7, 2020	

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be labeled, indicating the name of the product and use-by-date.

1b. The Facility failed to clean and store utensils under sanitary conditions.

An inspection of the facility kitchen on 2/4/2020 at approximately 1:51 p.m., yielded an observation of 2 coffee cups on a rack resting on the conveyer belt from the dishwasher, with discolored residue on the inside of the cups. Additionally, 4 cups placed on storage shelves contained stained residue on the inside of the cups.

An interview with the Dietary Manager on 2/5/2020 at approximately 2:05 p.m. regarding kitchen sanitation was conducted. The Dietary Manager stated, "When I first got here the kitchen was filthy, there were problems with sanitation and food temperatures. I dipped the mugs in Dip-It and it does a good job at destaining. I started working on those yesterday."

On 2/06/2020 at approximately 10:15 a.m., the Regional Dietary Manager reported, "A work order has been submitted for a rinse agent."

During an inspection of the facility kitchen on 02/06/2020 at approximately 10:30 a.m., coffee cups placed on holding racks were observed with residue on the inside of them.

There were no policies provided regarding maintenance of Resident dishes.

These findings were reviewed with the facility Administrator during a meeting on 02/06/2020 at approximately 3:00 p.m.

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F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		3/7/20

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F 842	Continued From page 72 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review the facility staff failed to ensure an accurate medical record for 1 of 53 residents in the survey sample, Resident #255. The February 2020 Treatment Administration Record (TAR) was not accurate for the application and removal of a compression stocking as ordered. The findings included:	F 842	842 1. Resident #255 discharged on 2/17/20. 2. Residents with orders for compression stockings were reviewed to ensure that the medical records are complete and accurately reflect use of the compression stockings. 3. Nurses will be educated on: a. Documentation of medications and treatments	

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F 842	Continued From page 73 Resident #255 was admitted to the facility on 1/23/20 with diagnoses to include but not limited to diabetes, chronic pain, and acquired right leg above the knee amputation. An admission MDS had not been completed prior to survey. The resident was alert and orientated to person, place and time. The physician progress noted dated 2/3/20 read, in part: "...alert, responsive and appears to be in no acute distress. Patient had been concerned on 02/02/2020 that his left foot was edematous and his shoe was not fitting. Physical exam: Edema/varicosities of extremities- Trace nonpitting left pedal edema. Diagnosis, Assessment, Plan-Peripheral edema- Compression stocking apply to left lower extremity QAM (every morning) & remove QPM (every evening)." The physician orders dated 2/4/20 instructed the staff to apply a compression stocking to the resident's left lower extremity (LLE) every morning and remove every evening for the diagnosis and treatment of edema (fluid retention or swelling). The resident was observed on 2/4/20 at 4:50 p.m., and on 2/5/20 at 2:22 p.m., in bed without a compression stocking to the left lower extremity. At 3:24 p.m., the resident was awake sitting on the edge of bed, he stated the staff have not offered or provided a compression stocking as ordered, he stated he would accept it if offered. On 2/6/20 at 11:15 a.m., the resident was observed in bed. The compression stocking was not observed on the LLE. The resident was asked if the staff had offered the stocking and he	F 842	b. Documentation of reason medication/treatment is not administered as ordered 4. A Registered Nurse will complete a random weekly monitor of medical records to ensure that medications and treatments are documented as administered and that the reason is documented if a medication or treatment is not administered as ordered. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: March 7, 2020	

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stated," No, no one has offered one."

The Treatment Administration Record for February 2020 was inaccurate. The entry for the compression stocking to the LLE was initiated by the staff as being applied in the morning and removed in the evening on 2/4/20 and 2/5/20.

On 2/6/20 at 11:20 a.m., the Licensed Practical Nurse (LPN #7) assigned to care for the resident was interviewed. She was asked about the compression stocking for Resident # 255. She stated, "I know he didn't have them on yesterday". When showed the TAR documentation that she had initialed on 2/4/20 and 2/5/20 as having applied the compression stocking she said, " I must have just clicked on it". She further stated, " I'll make sure he get's one on today." When asked if the facility had the compression stocking available she stated, "Yes."

The above findings was shared with the Director of Nursing (DON) and the Nurse Consultant on 2/6/20 at approximately 11: 45 a.m. The DON stated, "If you sign for it, you do it."

The Nursing Policy and Procedure titled Nursing Documentation Policy Number 2003, effective date 11/01/19 read, in part:
Licensed Nurses and CNAs will document all pertinent nursing assessments, care interventions, and follow up actions in the medical record.
3. Entries will be made as soon as possible after an event or observation is made. An entry will never be made in advance.
17. It is illegal to willfully falsify entries on MARs, TARs, and other flow sheet records, and illegal to go back and fill in "holes"...Self-monitoring, or an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 842	Continued From page 75 end-of-the-shift review should occur in order to assure that documentation is complete. No additional information was provided prior to exit.	F 842		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, facility documentation review, and staff interviews, the facility staff in the kitchen failed to maintain kitchen equipment in proper working condition. The findings included: During an initial inspection of the facility kitchen occurring on 02/04/2020 at approximately 11:37 a.m., it was found that the 3-compartment sink was inoperable. An interview conducted with the Dietary Manager on 02/04/2020 at approximately 12:00 p.m. regarding the sanitation testing of the 3 compartment sink which yielded the response, "We don't use that, we use the dishwasher." On 02/05/2020 at approximately 10:17 a.m. an interview with the Dietary Manager was conducted as to the status of the 3 compartment sink. The Dietary Manager stated, "The sink is non-operational. Water will not keep in the sink. Water runs in the floor."	F 908	908 1. The 3-compartment sink was repaired on 2/6/20. 2. Kitchen equipment was observed to ensure that it is maintained in proper working condition. 3. Dietary Service staff were educated on completion of a work order when kitchen equipment is noted to be inoperable. 4. The Dietary Service Manager will complete a random weekly review of kitchen equipment to ensure that the equipment is operational. 5. Issues noted will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: March 7, 2020	3/7/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 908	Continued From page 76 These findings were reviewed with the Administrator during a meeting on 02/06/2020 at approximately 3:00 p.m.	F 908		