STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495354	A. BUILDING _____ B. WING _____	09/25/2019

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GREENSPRING VILLAGE	7470 SPRING VILLAGE DR SPRINGFIELD, VA 22150

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 09/24/2019 through 09/25/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities. The census in this 136 bed facility was 79 at the time of the survey. No complaints were investigated.	E 000	Greenspring Village is filing this Plan of Correction for purposes of regulatory compliance. The Facility is submitting this Plan of Correction to comply with applicable law and not as an admission or statement of agreement with respect to the alleged deficiencies herein.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 09/24/2019 through 09/25/2019. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Life Safety Code report will follow. The census in this 136 certified bed facility was 79 at the time of the survey. The survey sample consisted of 18 current Resident reviews and two closed record reviews.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F 623		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Donna L. Epps	Administrator	10-11-2019

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

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F 623	Continued From page 1 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in	F 623	F 623 Failure to notify the local Ombudsman of a resident transfer to the hospital. 1. The local Ombudsman was notified of the discharge of resident #2 on 9/25/2019 2. The social worker conducted an audit of all admissions, discharges and transfers for the month of September 2019 and validated notification to the local Ombudsman. 3. The Assistant Administrator re-educated the social worker on notification to the local Ombudsman of resident discharges and transfers to the hospital. 4. The social worker will perform a monthly audit of the admission, discharge and transfer report to validate notification to the Ombudsman x 3 months and the results of these audits will be reported to QA/PI committee each month for 3 months 5. Date of Compliance:11/5/2019	11/05/2019

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F 623	Continued From page 2 completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §	F 623		

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F 623	Continued From page 3 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed, for one of 18 residents in the survey sample, to notify the local Ombudsman of a resident's transfer to the hospital. The findings were: Resident # 2 was admitted to the facility on 8/28/18, and most recently readmitted on 6/20/19 with diagnoses that included anemia, renal insufficiency, hypothyroidism, Non-Alzheimer's dementia, Parkinson's disease, chronic obstructive pulmonary disease, and history of malignant neoplasm of the prostate. According to the most recent Minimum Data Set, a Significant Change with an Assessment Reference Date of 9/1/19, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with severely impaired daily decision making skills. Review of the Nurses Notes in the resident's Electronic Health Record revealed the following entry: 6/17/19 - 4:10 p.m. - "Resident is alert and oriented to self, observed with confusion and forgetfulness, cognition is not within his usual baseline, observed with incontinent of saliva evident with drooling, no facial drooping noted. Resident was unable to verbalize if he had chest pain or headache, decreased strength noted to both upper and lower extremity. Resident is not responding well to interacting with others like he would, unable to give answer regular question	F 623		

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F 623	Continued From page 4 when asked staff observed a decline in resident during care, and in the dining at meal time. (Name) NP (Nurse Practitioner) notified, order to send resident to the ER to r/o (rule out) stroke...Son (name) notified of his transfer to ER to r/o stroke...." At 4:10 p.m. on 9/24/19 the Assistant Administrator was asked for assistance in locating the notice to the Ombudsman of the resident's transfer to the hospital, At 4:30 p.m. the Assistant Administrator returned to the surveyor and said, "I was unable to locate any notice to the Ombudsman."	F 623		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		

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F 657	Continued From page 5 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, facility staff failed to review and revise comprehensive care plans (CCP) for two of 20 residents in the survey sample, Residents #42 and #39. Neither resident's care plans were reviewed by a complete interdisciplinary team (IDT). Resident #42's care plan did not include fall interventions, or use of siderails. Resident #39's care plan did not include interventions for weight loss. Findings included: 1. Resident #42 was admitted to the facility on 05/04/2019 with diagnoses including, but not limited to: multiple pelvic fractures, osteoporosis, dementia and depression. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 08/05/2019. Resident #42 was assessed as moderately impaired in her cognitive status with a total cognitive score of nine (09) out of 15. Progress notes reviewed on 09/24/2019 at 10:15 a.m. included documentation of falls on 05/30/19, 08/28/19, and 09/23/19. Subsequent review of Resident #42's CCP under falls included: "Goal(s): will need to maintain a	F 657	F657- Care Plan Timing and Revision 1. Resident #42 and #39 care plans were reviewed and revised by the interdisciplinary team to reflect resident needs. 2. a-The Director of Nursing or designee will conduct a onetime audit of current residents that have sustained a fall during the month of September 2019 to ensure their care plans have been updated with current fall interventions appropriate for the resident. b-The Registered Dietician or designee will conduct a onetime audit of current residents that have sustained a significant weight loss (5% or more in September or 10% or more in the past 6 months) to ensure that weight loss prevention interventions are addressed in the care plan. 3. The Nurse Educator or designee will re-educate the interdisciplinary team on the policy and guidelines regarding timely review and revision of resident care plans as their care needs change in relation to falls and weight management. 4. An audit of 10 resident care plans will be conducted weekly x4, then monthly x2 to validate that the care plans are comprehensive and have been revised timely. The findings will be reported in the monthly QAPI meetings and additional audits will be initiated if the findings reflect a need for them. 5. Date of Compliance: 11/05/2019	11/05/19

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F 657	Continued From page 6	F 657		

safe environment to allow me to ambulate freely to minimize injury or falls daily. Care Plan Approaches...staff will total assist with ADL's [activities of daily living] for safety precaution maintained...Devices: Low Bed..." There was no mention of actual falls or any additional interventions used.

The care plan for bed mobility and transfers included: "Goals: I will need total assistance with bed mobility daily. I will need total assistance to transfer daily...I need the following devices to be as independent as possible: U-Bar right side U-Bar left side...U-Bar on both sides..." Resident #42's bed was observed on 09/25/2019 at 9:45 a.m. and 11:25 a.m. with one quarter rails up on each side of the bed, not U-Bars. The resident was lying in the bed during both observations.

A clinical note written by the Social Worker, dated 08/05/2019 included: "Quarterly Note: Advance directives reviewed...Medications reviewed. LTC [long term care] status at this time. Intake fair. Daughter to be present for family care plan next week. Social Worker to monitor as indicated. Remains long term care due to self care needs."

A second clinical note written by the Social Worker, dated 08/14/2019 included: Family meeting: Daughter and resident present..." An Interdisciplinary Care Plan Meeting Record dated 08/14/19 was signed by the Social Worker and the resident's daughter.

The Unit Manager on second floor, RN #1 (registered nurse) was interviewed on 09/25/2019 at 9:00 a.m. regarding who should attend care plan meetings. RN #1 stated, "The nurse, social worker, nursing assistant, activities, dietitian and

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F 657	Continued From page 7 therapy, if involved, and of course the resident or family. MDS puts out a list of the quarterly and annual assessments that are due each month. The list is sent to the managers on the floor. The managers should then assign the assessments to the nurse caring for the resident. The nurse can look up any assessments that are due under the assessment tab on the computer. Once the assessment is posted on the computer it's the nurses responsibility to complete the nursing sections." Social Worker, Other #2, was interviewed on 09/25/2019 at 9:10 a.m. regarding care plan meetings. Other #2 stated, "We meet on the date on the care plan with the disciplines and if the resident or family cannot attend on that date we set a separate date to meet with them either in person or via phone. The disciplines met on 08/05/19 and I met with the resident and her daughter on 08/14/19." Regarding who attended the discipline care plan meeting, Other #2 stated, "I usually write in the note who attends the meeting. Did I not for this one? I can tell you for [Name] Resident #42, social work, activities and the daughter met." Regarding why a nurse did not attend, Other #2 just shook her head no and then stated, "They often give us written documentation to read during the meeting, but are not present." A second Social Worker, Other #3 stated, "They want us to read this information, but they aren't there to answer questions or anything. This is out of our scope of practice and if we speak to anything then we are reprimanded for that." The Administrator and DON (director of nursing) were informed of the above findings during a	F 657		

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F 657	Continued From page 8 meeting with the survey team on 09/25/2019 at 1:00 p.m. No further information was received by the survey team prior to the exit conference. 2. Resident #39 was admitted to the facility on 7/23/19 with diagnoses that included left humerus fracture, dementia, atrial fibrillation, cellulitis, high blood pressure, chronic venous insufficiency, urinary tract infection, anemia, diabetes, cirrhosis and history of gastrointestinal bleed. The minimum data set (MDS) dated 8/6/19 assessed Resident #39 with moderately impaired cognitive skills. Resident #39's clinical record documented the resident was assessed on 9/5/19 with a significant weight loss. The resident weighed 180 pounds (lbs.) on 8/4/19 and weighed 168.1 lbs. on 9/5/19 indicating a 6.6% weight loss. A note by the registered dietitian (RD) dated 9/13/19 documented the resident routinely ate independently in the dining room with intake amounts of approximately 50%. This note documented, "...PO [oral] intake [approximately] 50% which meets only 80% calorie, 83% protein needs to prevent significant wt [weight] loss. Meds reviewed, lantus [insulin] increased d/t [due to] elevated BS [blood sugar]...Resident not appropriate for education d/t cognition. Resident at high nutrition risk/risk for continued significant wt loss/skin breakdown/dehydration d/t progressive dementia, obesity, DM [diabetes], wt loss, need for assist at meals, abnormal labs, not meeting estimated needs and age..." The clinical record documented the resident was prescribed a regular, limited concentrated sweets diet. On 9/5/19, a high protein evening snack was started in addition to weekly weights, assistance/cueing at meals and an increased	F 657		

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F 657	Continued From page 9 dosage of insulin. Resident #39's plan of care (revised 9/13/19) included no revisions regarding the resident's significant weight loss. The plan listed the resident required extensive assistance at meals. Interventions to prevent significant weight loss included, "Provide me a LCS [low concentrated sweet] diet, encourage no sugar added beverages and desserts...Offer me my favorite foods and beverages as available...I would like to choose my own foods with the ordered consistency...Obtain and monitor my weights, monitor my po tolerance, labs, skin, bowels and meds..." The care plan made no mention of the resident's 6.6% weight loss identified on 9/5/19 and included no revisions implemented in response to the weight loss. Resident #39's care plan meetings dated 7/30/19 and 9/13/19 did not include participation by an interdisciplinary team and no participation by the facility's RD. Only the social worker and representatives from therapy (occupational, speech, physical) attended the care plan meeting held on 7/30/19. The care plan meeting held on 9/13/19 included participation by the social worker, a registered nurse (RN) from assistive living, occupational therapy and the resident's family member. There was no participation at either meeting by the RD, a facility RN or a certified nurses' aide (CNA) caring for the resident. On 9/24/19 at 3:52 p.m., the unit manager (RN #1) was interviewed about Resident #39's care plan and lack of interdisciplinary team participation in the care plan meetings. RN #1 stated usually the nurse and aide caring for the	F 657		

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F 657	Continued From page 10	F 657		

resident participated in the meetings and care plan review. RN #1 reviewed the care plan and stated she did not see where the direct care staff or RD participated in the meetings. RN #1 stated the social worker coordinated the care plan meetings and the RD was responsible for updating the care plan regarding significant weight loss.

On 9/24/19 at 3:55 p.m., the RD (other staff #1) was interviewed about Resident #39's weight loss and care plan. The RD stated she needed to update Resident #39's plan of care. The RD stated the resident was in assisted living prior to admission to the nursing facility. The RD stated the resident was having adjustments done to her dentures and she initiated weekly weights, a high protein evening snack and a requirement for assistance and cueing at meals in addition to insulin doses adjustments. The RD stated she would expect the weight loss interventions to be added to the plan of care. When asked why she did not participate in either of Resident #39's care plan meetings, the RD stated, "I was not able to attend."

On 9/24/19 at 4:18 p.m., the director of nursing (DON) was interviewed about participation in the care plan meetings. The DON stated the social worker coordinated meetings and multiple disciplines could attend the meetings. The DON stated the social worker could speak to interdisciplinary team participation in care plan meetings.

On 9/25/19 at 9:00 a.m., the facility's social worker (other staff #2) was interviewed about interdisciplinary team participation in Resident #39's care plan meetings. The social worker

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F 657	Continued From page 11 stated she notified the resident, family and facility staff including nursing of the meeting dates/times. The social worker stated there were no representatives from dietary/nutrition, nursing or a direct care aide at Resident #39's meetings and care plan review. The social worker stated the RN that attended the meeting on 9/13/19 worked in the assisted living area and was there to discuss possible discharge plans at the request of the family. The social worker stated the RD did not attend either meeting and there was no other staff person attending representing nutrition concerns. The social worker stated, "We [social services] invite them but all disciplines don't always come." The facility's policy titled Care/Service Plans (revised April 2019) documented, "Each guest/resident will have an individualized care/service plan developed at time of admission/readmission. Each guest/resident individualized care/service plan will be revised to reflect any changes in condition and will be reviewed at designated internals [intervals] at a minimum based on service line (Skilled Nursing/Long Term Care...)..." (sic) This policy documented the long-term care interdisciplinary team was to include at a minimum, "...the resident/responsible party, medical provider, registered nurse, care associate and member of food and nutritional staff..." This finding was reviewed with the administrator and director of nursing during a meeting on 9/25/19 at 1:00 p.m.	F 657		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4)	F 700		

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F 700	Continued From page 12 §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review the facility staff failed to assess seven of twenty residents for bed rail safety (Residents # 12, 16, 48, 39, 65, 66, and 42). Findings include: 1. Resident # 12 was initially admitted to the facility 8/4/14 with a readmission date of 9/8/16. Diagnoses for Resident # 12 included, but were not limited to: high blood pressure, vascular dementia, depression, muscle weakness, repeated falls, and unsteadiness of feet.	F 700	**F 700 Bed rails** 1. Residents #12, #16, #39, #42, #48, #65 and #66 were all assessed for the need of assistive devices by the interdisciplinary team and care plans were updated to reflect their current needs and interventions implemented by 9/27/2019. 2. The Clinical Manager or designee will perform a 100% audit of residents with orders for bedrails to ensure that they have been evaluated for the appropriate and safe use of bedrails. 3. The Nurse Educator will re-educate the interdisciplinary team on the policy and guidelines regarding the use of bedrails. 4. An audit of 10 residents will be conducted weekly x 4, then monthly for 2 months to validate that the policy and guidelines for implementing bedrails is being accurately followed. The findings will be reported in the monthly QAPI meetings and additional audits will be initiated if the findings reflect a need for them. 5. Date of Compliance: 11/05/2019	11/05/19

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F 700	Continued From page 13 The most recent MDS (minimum data set) was an annual review dated 9/1/19 and had the resident scored with severe cognitive impairment with a total summary score of 01 out of 15. On 9/24/19 at approximately 4:00 p.m. Resident # 12's room was observed. The door was partially closed. Moaning was heard coming from the room. Resident #12 was observed with her knees on the fall mat, her upper body across the bed, and her arms entangled in the grab rail. LPN (licensed practical nurse) #2 was requested to assist the resident. LPN #2 came to room with CNA (certified nursing assistant) #2 and proceeded to get Resident # 12's arms out of the rail and laid her down on the fall mat. CNA #2 asked the resident if she was hurt, and Resident # 12 responded "Yes." When the resident was asked where she hurt, Resident # 12 began yelling "Please! Please!" The nurse assessed her and determined there was no injury. On 9/24/19 at approximately 4:30 p.m. the clinical record was reviewed. No information could be located about the use of the bed rail. There were no physician orders, no assessment, and no informed consent. The care plan was reviewed, and revealed interventions for mobility. The goals were documented as "I will need extensive assistance with bed mobility daily...I need the following devices to be as independent as possible: U-bar left side." The care plan was dated 7/15/19. On 9/24/19 at 4:45 p.m. RN (registered nurse) # 2, who was the nurse manager, was asked for assistance in locating the assessment, order, and signed consent form for the use of the bed rails.	F 700		

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F 700	Continued From page 14 She was also asked for a copy of the facility policy for bed rail use. RN # 2 stated "Well, those aren't actually a bed rail. The U-bars are considered a mobility device." RN # 2 was advised per regulation, any bar attached to the frame of a bed was considered a bed rail. RN # 2 stated "I did not know that." RN # 2 was informed at that time of the above observation of Resident # 12. RN # 2 also stated that therapy had evaluated the resident for the bed rail usage. On 9/24/19 at 5:35 p.m. the administrator and assistant administrator presented a form titled "Bed Rail Entrapment Risk Evaluation." The administrator was asked if there was an informed consent signed, and a physician order. The "Bed Rail Entrapment Risk Evaluation" form was dated 1/2/19. The form included the following documentation: "The resident's risks of entrapment and possible benefits of bed rails have been evaluated. The following components of the resident evaluation were included in the review (check all): " The only item checked was "Mobility (in and out of bed)." The form further directed, "Based on evaluation of the resident's individualized needs, risk of injury and entrapment, as well as benefits, the interdisciplinary team has determined: The resident will (sic) benefit from a Bed Rail. The following recommendations are being made based on the interdisciplinary team review: Left Bed Rail based on individual resident need..." "Nursing" was the only discipline checked as participating in the evaluation. Other discipline options were Physical Therapy (PT), Occupational Therapy (OT), Social worker (SW), MD/NP (Medical Director/Nurse Practitioner), and Programming.	F 700		

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F 700	Continued From page 15 On 9/24/19 at 5:45 p.m. the administrator stated "I cannot find any further documentation in the medical record. What I gave you is all I can locate." On 9/24/19 at 5:45 p.m. after review of the bed rail policy, the administrator was asked for all the documentation outlined in the policy that was done for Resident # 12. The administrator was also asked if the assessment was considered "complete" as the components for the evaluation was only checked for mobility. The administrator stated that per the policy, all the components were not checked as having been done, so was probably not complete. The administrator was also asked for documentation of the evaluation. The administrator stated, "I cannot find any further documentation in the medical record. What I gave you is all I can locate." On 9/25/19 at 8:45 a.m. CNA # 1 was observed providing care for Resident # 12. CNA # 1 was asked if Resident # 12 was able to follow commands to use the bed rail. CNA # 1 stated "Yes, she can hold on to it if I tell her to so I can transfer her to her wheel chair...I also have to tell her to let go..." The resident's bed was observed at this time without the bed rail. CNA # 1 stated "Yes, it was off when I came in this morning." On 9/25/19 at approximately 8:55 a.m. the Rehab Manager, OS (other staff) # 5, was interviewed about the evaluation of Resident # 12. OS # 5 was informed RN # 2 had stated therapy had evaluated the resident for use of the bed rail. OS # 5 stated "I will look into it and see if an evaluation was done; we follow the policy and wait on a referral from nursing..." At 9:40 a.m.	F 700		

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F 700	Continued From page 16 OS # 5 stated "There has been no assessment of Resident # 12 since 2017." On 9/25/19 at 9:52 a.m. the administrator, assistant administrator, and RN # 2 were interviewed about the bed rail assessments per the policy. RN # 2 was asked who removed Resident # 12's bed rail, and when was it removed. RN # 2 stated "I took it off yesterday as an immediate intervention to what happened. A new assessment was also done, as well as, the nurse practitioner doing an order for the rehab assessment..." RN # 2 was then asked what alternatives had been put in place after taking away the bed rail. RN # 2 stated "Frequent rounding by nursing." The administrator was asked if the bed rail policy and assessment was inclusive for measuring the bed to ensure there were no entrapment risks, and she stated it was. RN # 2 was asked if she had measured the bed, and she stated she had not. A copy of the new assessment, signed consent, and the order for rehab evaluation was requested at that time. The requested information was not received. The administrator, DON (director of nursing), and assistant administrator were informed of the above findings during a meeting with facility staff 9/25/19 beginning at 1:10 p.m. No further information was provided prior to the exit conference. 2. Resident # 16 was admitted to the facility 10/3/16 with diagnoses to include, but not limited to: high blood pressure, paraplegia, chronic, stable pressure ulcer, and muscle weakness. The most recent MDS (minimum data set) was a	F 700		

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F 700	Continued From page 17 quarterly review dated 9/23/19 and had Resident # 16 coded with moderate impairment in cognition with a total summary score of 12 out of 15. On 9/25/19 at 8:00 a.m. Resident # 16 was observed in bed. There were bilateral U-bars on the bed, and a trapeze bar above the bed. Resident # 16 was asked how she used the U-bars. She stated "I don't use them as much as I used to; I use the trapeze bar mostly. But if I need to roll from side to side, or if staff are cleaning me, I can use them to turn." Resident # 16 was asked if she had received any education about the bed rails, or had signed a consent for their use. Resident # 16 stated "No. I don't believe I have." The clinical record was reviewed 9/25/19 at 8:30 a.m. There was a Bed Rail Entrapment Risk Evaluation form located in the record dated 9/24/19. The form was only marked as evaluated for mobility, and was signed by nursing as the only discipline involved in the assessment. A signed consent was not located, nor was an order for a Rehab evaluation. On 9/25/19 at 9:52 a.m. the administrator, assistant administrator, and RN # 2 were interviewed about the bed rail assessments per the policy. RN # 2 was asked why an assessment had been done 9/24/19, and if any other assessment for Resident # 16 had been done prior to that. RN # 2 stated she did not know, she had been employed at the facility for three (3) years, and Resident # 16 had the bed rails ever since she had began employment there. The administrator was asked if the bed rail policy and assessment was inclusive for measuring the bed to ensure there were no	F 700		

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F 700	Continued From page 18 entrapment risks, and she stated it was. RN # 2 was asked if she had measured the bed, and she stated she had not. The administrator was asked what precipitated an assessment for Resident # 16. The administrator replied "Identified like residents, based on the incident that occurred 9/24/19 to the other resident, were all re-evaluated and a plan of correction was started." The assistant administrator presented a copy of a signed consent 9/25/19 at approximately 2:00 p.m. The name of Resident # 16's son was written by RN # 2 who had also signed the form. There was no documentation on the form of education provided. The assistant administrator was asked about the lack of documentation on the form, and RN # 2 signing the form for the son. The administrator, DON (director of nursing), and assistant administrator were informed of the above findings during a meeting with facility staff 9/25/19 beginning at 1:10 p.m. No further information was provided prior to the exit conference. 3. Resident #39 was admitted to the facility on 7/23/19 with diagnoses that included left humerus fracture, dementia, atrial fibrillation, cellulitis, high blood pressure, chronic venous insufficiency, urinary tract infection, anemia, diabetes, cirrhosis and history of gastrointestinal bleed. The minimum data set (MDS) dated 8/6/19 assessed Resident #39 with moderately impaired cognitive skills and as requiring the extensive assistance of one person for bed mobility and transfers. On 9/25/19 at 8:15 a.m., Resident #39 was observed in bed with quarter length side rails in	F 700		

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F 700	Continued From page 19 the up position near the head of the bed. Fall mats were in place on both sides of the bed. Review of Resident #39's clinical record on 9/24/19 documented no assessment regarding the use of bed rails. The record documented no prior attempts of any alternatives to the rails, no assessment for entrapment risks, no informed consent from the resident's family or any review of the bed environment regarding safety/entrapment risks for Resident #39. Resident #39's clinical record documented the resident had an unwitnessed fall from the bed on 9/9/19. A floor mat was implemented in response to the fall. The post-fall assessment dated 9/9/19 made no mention of the resident's side rails use. There was no re-assessment of Resident #39 regarding safe bed rail use after the unwitnessed fall on 9/9/19. Resident #39's plan of care (revised 9/13/19) listed the resident required help to maintain a safe environment. Interventions listed to prevent falls/injury included monitoring by staff, call pendant, private sitter from 8:00 a.m. to 8:00 p.m. each day and fall mats when in bed. The care plan listed the resident required extensive assistance with bed mobility and transfers and had cognitive impairment that included confusion. The quarter length side rails were listed as an intervention under transfer assistance to allow resident "to be as independent as possible." The care plan listed no safety concerns with use of the bed rails. On 9/25/19 at 12:15 p.m., the registered nurse unit manager (RN #1) was interviewed about any prior assessment of Resident #39's bed rails	F 700		

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F 700	Continued From page 20 regarding entrapment risks. RN #1 stated direct care staff reported that Resident #39 held the rails when turning in bed during care. RN #1 stated she was not aware of any prior assessments and/or consents regarding the bed rails. This finding was reviewed with the administrator and director of nursing during a meeting on 9/25/19 at 1:00 p.m. 4. Resident #48 was admitted to the facility on 6/15/18 with a readmission on 8/16/19. Diagnoses for Resident #48 included high blood pressure, aortic stenosis, stroke, anemia, hypothyroidism, expressive aphasia and atrial fibrillation. The minimum data set (MDS) dated 8/30/19 assessed Resident #48 with severely impaired cognitive skills. This MDS listed the resident required the extensive assistance of one person for bed mobility and the assistance of two people for transfers. On 9/25/19 at 8:15 a.m., Resident #48 was observed in her room. Resident #48's bed had two grab rails mounted near the head of the bed in the raised position. Review of Resident #48's clinical record on 9/24/19 documented no assessment regarding the use of bed rails. The record documented no prior attempts of any alternatives to the rails, no assessment for entrapment risks, no informed consent from the resident's family or any review of the bed environment regarding safety/entrapment risks for Resident #48. Resident #48's plan of care (revised 8/16/19) listed the resident needed encouragement to use	F 700		

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F 700	Continued From page 21 adaptive equipment to minimize falls/injury. Interventions listed to prevent falls included, use of call light, low bed, anticipation of needs and therapy as needed. The care plan listed the resident had cognitive impairment and at times became "agitated" in the late afternoon. The use of a "U-bar" was listed as an intervention under bed mobility to allow resident "to be as independent as possible." The care plan listed no safety concerns with use of the bed rails. On 9/25/19 at 12:15 p.m., the registered nurse unit manager (RN #1) was interviewed about any prior assessment of Resident #39's bed rails regarding entrapment risks. RN #1 stated direct care staff reported that Resident #48 held the grab bars when turning in bed when care was provided. RN #1 stated she was not aware of any prior assessments and/or consents regarding the bed rails. This finding was reviewed with the administrator and director of nursing during a meeting on 9/25/19 at 1:00 p.m. 5. Resident # 65 originally admitted to the facility on 03/22/19 and most recently readmitted on 07/22/19. Diagnoses included hospice encounter, muscle weakness, Parkinson's Disease, depression, anxiety, dementia, and chondrosarcoma (malignant bone cancer). The most recent minimum data set (MDS) dated 08/19/19 which was a significant change assessed Resident #65 as severely cognitively impaired with a score of 2 out of 15 and having periods of fluctuating inattention and disorganized thinking. Under Section G - Functional Status, Resident #65 was assessed as requiring extensive assistance with two person physical	F 700		

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F 700	Continued From page 22 assistance for bed mobility, transfers, locomotion, toileting, personal hygiene, and dressing; and requiring total assistance with one personal physical assistance for bathing and eating. During the initial tour on 09/24/19, Resident #65 was observed in bed. The resident was observed on an alternating air mattress with grab bars in the up position on both sides of the bed. Resident #65 was observed again on 09/24/19 at 2:00 p.m. and on 09/25/19 at 10:30 a.m. in bed with both grab bars in the up position. On 09/25/19 at 10:30 a.m., Resident #65's private duty aide (Other Staff, OS #6) was interviewed regarding the Resident's ability to use the grab bars. OS #6 stated Resident #65 was able to follow commands and use the grab bars for turning and repositioning. OS #6 was asked how long had the grab bars and air mattress been in place. OS #6 stated he was not sure. OS #6 stated Resident #65 has private duty aides 24/7 and is never alone. During the interview, Resident #65 reached over to his left side and grabbed the bar and smiled. An attempt to interview Resident #65 about the grab bars was unsuccessful as he had non-sequential conversation. On 09/25/19 at 11 a.m., Resident #65's clinical record was reviewed. Observed was a "Bed Rail Entrapment Risk Evaluation" dated 09/11/19. The evaluation documented the following checked items: "The following components of the resident evaluation were included in the review (check all):...Mobility (in and out of bed)...Based on evaluation of the resident's individualized needs, risk of injury and entrapment, as well as	F 700		

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F 700	Continued From page 23 benefits, the interdisciplinary team has determined:...The resident will benefit from a Bed Rail...The following recommendations are being made based on the interdisciplinary team review:..Bed rails to both sides of the bed based on individualized resident need...Refer to resident to Rehab for evaluation of appropriate resident alternatives to Bed Rail...Disciplines participating in evaluation:...Nursing..." A review of the care plans documented the following: "3a. Bed Mobility - Functional Status... I need extensive assistance with bed mobility daily...I need the following devices to be as independent as possible: U-Bar right side, U-Bar left side" Date Begun:____/____/____Date of Next Review: 12/2019." "3b: Transferring - Functional Status.... I need extensive assistance to transfer daily.... I need the following devices to be as independent as possible: U-Bar on both sides..... Date Begun: ____/____/____. Date of Next Review: 12/2019." "9. Skin Integrity.... APM (alternating air pressure mattress).... Date Begun: 09/11/2019. Date of Next Review: 12/11/2019." A review of the current physician orders did not document orders for the grab/u-bars or the air mattress. On 09/25/19 at 11:15 a.m. the unit manager (RN #2) was interviewed regarding the grab bars and air mattress. RN #2 stated she completed the bed rail evaluation on 09/11/19 because the resident was recently admitted to hospice. RN #2 was asked if other disciplines participated in the evaluation and she stated a referral may have	F 700		

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F 700	Continued From page 24	F 700		

been sent to rehab, but she would check and follow-up with the survey team. RN #2 stated the facility considered the device as a "U-Bar" and not a grab bar and Resident #65 required the device for mobility and transfers. RN #2 stated Resident #65 was able to follow commands and safely use the bars despite his cognitive status and because he had private duty aides 24/7 it was a safe environment. RN #2 was asked if an order was required for the grab/U-bars and the air mattress. RN #2 stated no because they were considered as interventions. RN #2 was asked how long the grab/U-bars and air mattress had been in place and she said she was not sure, but would check with the rehab department and follow-up with the survey team. RN #2 was asked if a consent was obtained for use of the grab/U-bars and RN #2 stated she would have to check and follow-up with the survey team. RN #2 was asked if any measurements were taken when the air mattress was placed on the bed with the grab bars. RN #2 stated she did not know this information.

On 09/25/19 at 12:47 p.m., these findings were reviewed with the facility's administrator, assistant administrator, and interim director of nursing (DON). The DON was asked if an order was required for an air mattress. The DON stated she would need to check. The DON was asked to provide documentation on when the grab/U-bars and air mattress were implemented and if there was a consent for use of the devices. The DON stated she would follow-up with the survey team.

On 09/24/19 at 2:18 p.m., the assistant administrator returned to the conference room and advised the survey team that the clinical record had been reviewed and the requested

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F 700	Continued From page 25 documentation was not located. No other information was provided to the survey team prior to the exit conference on 09/25/19 at 2:30 p.m. 6. Resident #66 was admitted to the facility on 02/04/2019 with the following diagnoses, including but not limited to: Hallucinations, leg edema, hypertension, Atrial fibrillation, aortic stenosis, anxiety, left hip fracture, and TIAs (mini strokes). The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 08/27/2019. Resident #66 was coded as being severely impaired in her cognitive status with a summary score of "03". On 09/25/2019 at approximately 10:30 a.m., Resident #66's bed was observed. She had an air mattress, and bilateral side rails on her bed. She was not in the bed. The clinical record was reviewed. A "Bed Rail Entrapment Risk Evaluation" dated 09/03/2019 was observed. The form contained the following instructions at the top: "The resident's risks of entrapment and possible benefits of bed rails have been evaluated. The following components of the resident evaluation were included in the review (check all)". Listed below were the following choices to check: "Medical diagnosis, conditions; Symptoms, and/or behavioral symptoms; Size and weight; Sleep habits; Medications(s); Acute medical or surgical interventions; Underlying medical conditions; Existence of delirium; Ability to toilet self safely; Cognition; Communication; Mobility (in and out of bed); Risk of falling". The only component	F 700		

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F 700	Continued From page 26 listed was: "Mobility (in and out of bed)". The next line on the form read: "Based on evaluation of the resident's individualized needs, risk of injury and entrapment, as well as benefits, the interdisciplinary team has determined: "The resident will benefit from a bed rail...The following recommendations are being made based on the interdisciplinary team review: "Bed rails to both sides of bed based on individualized resident need. Refer resident to Rehab for evaluation of appropriate resident alternatives to Bed Rail...Disciplines participating in evaluation: Nursing." The therapy notes were reviewed. No evaluation for appropriate alternatives to the side rails was present. The unit manager, RN (registered nurse) #2 was interviewed at approximately 11:30 a.m. regarding the use of side rails for Resident #66. She stated, "She uses them to move from side to side in the bed." She was asked when the rails were placed on the bed. She stated, "I don't know...they were there when I got here...they are on her care plan to use for mobility." She was asked if therapy had evaluated her for appropriate alternatives to the use of side rails. She stated, "She needs them for mobility in the bed, they help her move and turn side to side." During a meeting with the DON (director of nursing) and the administrator on 09/25/2019 at approximately 1:10 p.m., the above information was discussed. They were asked when the side rails and the air mattress had been implemented. At approximately 2:20 p.m., the administrative assistant came to the conference room and	F 700		

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F 700	Continued From page 27 stated, "We don't have any record of when the air mattress or the side rails were implemented." No further information was received prior to the exit conference on 09/25/2019. 7. Resident #42 was admitted to the facility on 05/04/2019 with diagnoses including, but not limited to: multiple pelvic fractures, osteoporosis, dementia and depression. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 08/05/2019. Resident #42 was assessed as moderately impaired in her cognitive status with a total cognitive score of nine (09) out of 15. Review of Resident #42's CCP on 09/24/2019 at approximately 10:15 a.m. included the following for bed mobility and transfers: "Goals: I will need total assistance with bed mobility daily. I will need total assistance to transfer daily...I need the following devices to be as independent as possible: U-Bar right side U-Bar left side...U-Bar on both sides..." Resident #42's bed was observed on 09/25/2019 at 9:45 a.m. and 11:25 a.m. with one quarter rail up on each side of the bed, not U-Bars. The resident was lying in the bed during both observations. A "Bed Rail Entrapment Risk Evaluation" dated 9/24/19 included: "...Based on evaluation of the resident's individualized needs, risk of injury and entrapment, as well as benefits, the interdisciplinary team has determined: The resident will benefit from a Bed Rail...The following recommendations are being made	F 700		

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F 700	Continued From page 28	F 700		

based on the interdisciplinary team review: Bed rails to both sides of bed based on individualized resident need. Refer to resident to Rehab for evaluation of appropriate resident alternatives to Bed Rail. Disciplines participating in evaluation."

No Rehab evaluation was located in the clinical record and no participating disciplines were marked on the evaluation. The evaluation was signed by the RN (registered nurse) on 9/24/2019.

A "Bed Rails Informed Consent" dated 9/24/19 at 7:30 p.m. was noted in the record. The consent was signed by two RN's, but was not signed by the resident or her patient representative.

The second floor unit manager, RN #1 (registered nurse) was interviewed on 09/25/2019 at 11:20 a.m. regarding siderail assessments and consents. RN #1 stated, "I cannot answer if any assessments were done previously. I haven't done any. I would assume they would be on the clinical record if they were done."

The facility policy for Bed Rails, Origination Date: 5/2018, Version Date: 6/2019 included: "Purpose/Scope: To identify a comprehensive process for resident assessment to include entrapment risk, identification of any alternatives prior to installation of bed rails based on each resident's individualized need and informed consent. Policy: Residents of continuing care will be evaluated for the appropriate and safe use of bed rails prior to their implementation. Definitions: ...Bed rails: are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or

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F 700	Continued From page 29 one-eighth lengths...Examples of bed rails include, but are not limited to: Side rails, bed side rails, and safety rails; and grab bars assist bars. Procedure: ...2. Upon admission, readmission or significant change in condition, the licensed nurse will assess/evaluate the resident's potential need for, as well as benefits and risks of bed rail usage...3. Each resident's assessment/evaluation will determine if a Bed Rail would be a safe and appropriate intervention. If the resident may benefit for bed rail usage, the licensed nurse will obtain an order for a Rehab evaluation. 4. The Rehabilitation (Rehab) Manager or designee will evaluate the resident's mobility and safety to determine appropriate equipment, assistive devices, bed rails or other alternatives to meet each resident's individualized goals and needs. 5. If bed rails are recommended and deemed safe and appropriate after a Rehab evaluation, the Licensed Nurse or Rehab Manager will communicate with the resident and/or representative the risks and benefits of the side rail utilization using the Bed Rail Information Sheet. 6. The resident's medical record will reflect the staff member providing the Bed Rail Information Sheet and risk/benefit education as well as the resident or resident representative that has received the risk/benefit education. 7. The resident or responsible party (if applicable) and staff member providing information to the resident will sign Bed Rail Informed Consent. 8. A copy of the signed Bed Rail Informed Consent will be maintained in the medical record...12. The Maintenance Department will install bed rails in accordance with manufacturer's instruction...14. The Maintenance Department or designee will conduct inspection of all bed frames, mattresses, and bed rails, as part of a regular maintenance	F 700		

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F 700	Continued From page 30 program to identify areas of possible entrapment and to make sure bed rails are still installed correctly..." (1) The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 09/25/2019 at approximately 1:00 p.m. No further information was received prior to the exit conference.	F 700		
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. §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	F 761		

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F 761	Continued From page 31 by: Based on observation, facility document review and staff interview, the facility staff failed to ensure expired medications and biologicals were not available for use in one of two medications rooms (Evergreen 2nd floor). The findings include: On 9/24/19 at 1:25 p.m., accompanied by licensed practical nurse (LPN #1), the medication room on the Evergreen second floor unit was inspected. A bottle of Lidocaine viscous medication labeled as expired on 9/13/19 was stored in the medication refrigerator. Also stored in the medication room were three expired "vacutainer" blood collection tubes. One tube had a manufacturer's expiration date of 1/31/19. Two additional tubes had expiration dates of 7/31/19. LPN #1 was interviewed at the time of this observation about the expired medication and collection tubes. LPN #1 stated the Lidocaine viscous was for a current resident and should have been discarded. LPN #1 stated the blood collection tubes were used by nursing for "stat" emergency labs. LPN #1 stated all nurses were responsible for monitoring the drug storage room and discarding expired items. The facility's policy titled Medication, Administration, Receipt, Storage & Disposal (revised 4/2019) documented, "All medications will be stored in accordance with manufacturer's instructions/recommendations...Discontinued or expired medications shall be destroyed within 30 days or sooner per state regulations, in the facility, or if unopened and properly labeled, returned to the pharmacy..."	F 761	F 761 Label/Store Drugs and Biologics 1. The expired bottle of Lidocaine viscous medication and collection tube was immediately thrown away. 2. The Clinical manager conducted an immediate audit of additional medication rooms on the skilled nursing neighborhoods to validate that no other expired medications were identified. 3. The Nurse Educator will re-educate licensed nurses on ensuring that expired medications and biological are not available for use. 4. The Director of Nursing or designee will conduct an inspection of the medication rooms to ensure that no expired medications and/or biologicals are available for use, weekly x 4 weeks, then monthly x 2 months. The results of these audits will be reported to the QA/PI committee each month for 3 months. 5. Date of Compliance:11/05/2019	11/05/19

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F 761	Continued From page 32 This finding was reviewed with the administrator and director of nursing during a meeting on 9/25/19 at 1:00 p.m.	F 761		
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on staff interview, and facility document review, the facility staff failed to ensure regular bed inspection of bed frames, mattresses and bed rails for 7 of 79 beds currently with bed rails in use during the survey (Residents # 12, 16, 48, 39, 65, 66, and 42). Findings include: On 9/25/19 at 8:30 a.m. the maintenance staff, identified as OS (other staff) # 4 was interviewed about the bed rail program, and asked if there was any documentation of bed measurements to ensure residents were not at risk for entrapment. OS # 4 stated "It's been over a year since we were told not to install bed rails. We are not involved. Anyone with a bed rail still on the bed probably had it prior to us no longer doing it." OS # 4 was asked if there were changes in the resident's weight, or a different mattress was applied to the bed, who would ensure the bed was free from an entrapment risk. OS # 4 stated	F 909	1. Identified residents with bed rails (#12,16,48,39,65, 66 and 42) bed frames and mattresses were inspected for possible risk for entrapment on 9/24/2019 2. A 100% inspection of resident's beds was conducted to identify possible areas of entrapment (bed frames, mattresses and bed rails) to ensure that beds are within safety standards. 3. The Maintenance Director and maintenance staff will be re-educated by the Nurse Educator or designee on the proper inspection of bed rails, bed frames and mattresses to identify risk of entrapment. 4. The maintenance director or designee will conduct monthly inspections of mattresses, bed frames and bed rails to identify possible areas of entrapment x 3 months. The result of these audits will be reported to QA/PI committee monthly for 3 months. 5. Date of Compliance: 11/05/2019	11/05/2019

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F 909	Continued From page 33 "Any changes like that the floor nurse/nurse manager is responsible to check." On 9/25/19 at 9:52 a.m. the administrator, assistant administrator, and RN # 2 were interviewed about the bed rail assessments per the policy. The administrator was asked if the bed rail policy and assessment was inclusive for measuring the bed to ensure there were no entrapment risks, and she stated it was. RN # 2 was asked if she had measured the beds, and she stated she had not. The policy for bed rail use was reviewed and directed: "Purpose/Scope: To identify a comprehensive process for resident assessment to include entrapment risk, identification of any alternatives prior to installation of bed rails based on each resident's individualized need and informed consent. Policy: Residents of continuing care will be evaluated for the appropriate and safe use of bed rails prior to their implementation." The administrator, DON (director of nursing), and assistant administrator were informed of the above findings during a meeting with facility staff 9/25/19 beginning at 1:10 p.m. No further information was provided prior to the exit conference.	F 909		