DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495425	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE REHAB CENTER AT BRISTOL	109 VILLAGE CIRCLE BRISTOL, VA 24201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite on 9/2/2020. Emergency Preparedness information was reviewed off-site on 9/2/2020 through 9/30/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. On 9/2/2020, the census in this 90 certified bed facility was 61. Facility staff reported having 22 current residents with positive COVID-19 results.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid complaint survey and COVID-19 Focused Infection Control Survey was conducted onsite on 9/2/2020. Infection control and complaint information was reviewed off site on 9/2/2020 through 10/26/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Corrections are not required for compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirement(s). Four (4) complaints were investigated during the survey. On 9/2/2020, the census in this 90 certified bed facility was 61. Facility staff reported having 22 current residents with positive COVID-19 results.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or	F 585	Note PoC date is 12/2/20 for all tags per administrator 1. Res. # 1 was discharged 3/21/20 and we were unable to obtain the information from the previous grievance. 2. All residents have the potential to be affected by this deficient practice. Audit performed to identify grievances that have resolved without a written resolution offered to the party filing the grievance. 3. Facility staff were trained to document and submit grievances to the social services director or their department manager. Resident Council was provided information regarding the process of filing a grievance. All grievances will be logged by the Social Services Director. Written	

			resolution will be offered to the family or resident filing the grievance 4. Review grievances weekly and document findings for 3 months.	

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

Circa West | Administrator | 11/26/20

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 585	Continued From page 2 Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility	F 585		

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F 585	Continued From page 3 or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interviews, the review of documents, and during the course of a complaint investigation, it was determined the facility staff failed to ensure grievances where addressed according to the facility's policy and procedure for one (1) of six (6) residents (Resident #1). The findings included: The facility staff failed to ensure a grievance related to Resident #1 was investigated and documented according to the facility policy. The facility staff failed to ensure that an individual filing a grievance was provided a written statement of the findings and actions that resulted from the facility's investigation. Resident #1's admission minimum data set (MDS) assessment had the resident assessed as able to make self understood and able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) score was documented as a 12 out of 15. Resident #1 was documented as requiring extensive assistance of two (2) or more individuals with bed mobility, transfers, and toilet use. Resident #1's diagnoses included, but were not limited to: heart failure, high blood pressure, diabetes, and chronic pain.	F 585		

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F 585	Continued From page 4 Review of the facility's grievance documentation included a grievance lodged on 3/11/2020 related to Resident #1. The 3/11/2020 grievance documentation included a statement that Resident #1's family member "reported a concern with nursing and filled out a grievance on March 3 and never heard from anyone ..." The investigation of the 3/11/2020 grievance failed to address the allegation of a previous grievance not being acted upon. During an interview on 10/15/2020 at 1:18 p.m., the facility's Social Worker (SW) stated he/she remembered discussing the concern about an earlier grievance while addressing the 3/11/2020 grievance. The SW acknowledged the 3/11/2020 grievance investigation documentation did not address the concern with the earlier grievance. The SW reported he/she had seen the facility's previous administrator with the written grievance in question. The SW also stated he/she had heard the previous administrator discussing the grievance with Resident #1's family member. The SW acknowledged there was not documentation of the earlier grievance reported in the 3/11/2020 grievance. The facility's grievance log was reviewed. It was noted that two (2) grievances related to Resident #1 had been entered into the grievance log. The complainant reported during a telephone interview that he/she had lodged 5-6 complaints with the facility. The two (2) grievances had documentation of an investigation being completed. The facility's social worker (SW) was asked about written communication/documentation being provided to the individual lodging the grievance as per the facility's policy. The SW reported all	F 585		

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F 585	Continued From page 5 communication with this individual was verbal communication; the SW confirmed written communication had not been provided to the individual lodging the grievance. The following information was found in a facility policy titled "Grievances/Complaints, Filing" (revised on April 2017): - "Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint." - "The resident, or person filing the grievance and/or complaint on behalf of the resident will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems." - "The results of all grievances files [sic], investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision." During an interview on 10/16/2020 at 10:10 a.m. with the facility's Administrator and Director of Nursing (DON). , the failure of the facility staff to ensure grievances related to Resident #1's were documented and completely investigated was discussed. The failure of facility staff to provide written information of the resolution of the grievance to the individual lodging the grievance was also discussed. The administrator reported grievance concerns had been identified during the facility's August 2020 quality committee meeting. The administrator acknowledged that the failure to provide the individual lodging the grievance with a written resolution was not identified by the facility's quality committee. The	F 585		

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F 585	Continued From page 6 facility's quality committee had identified concerns related to "lack of reporting of resident concerns" and "lack of timeliness in resolution of grievances". This is a complaint deficiency.	F 585		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interviews, the review of documents, and during the course of a complaint investigation, it was determined the facility staff failed to provide residents showers according to the facility's process for (4) of six (6) sampled residents (Resident #1, Resident #2, Resident #3, and Resident #4). The findings include: 1. The facility staff failed to ensure Resident #2's shower/bathing needs were consistently addressed. Resident #2's admission minimum data set (MDS) assessment assessed the resident as being able to make self understood and able to understand others. Resident #2's Brief Interview of Mental Status was scored as an eight (8) out of 15. Resident #2 was assessed as requiring limited assistance of one (1) individual with bed mobility, transfer, dressing, toileting, and personal hygiene. Resident #2 was assessed as requiring	F 677	1. Resident #1 discharged 3/21/20 Resident #2 discharged 1/14/20 Resident #3 discharged 3/27/20 Resident #4 identified to have not been offered showers twice weekly in the time period that was reviewed during the state licensure inspection. 2. Any resident has the potential to be affected by the deficient practices. Audit performed to assess whether current residents have documentation of showers offered twice weekly. 3. Direct care staff was provided education and bath team was implemented. In the absence of a bath team direct care staff will ensure that complete bath is offered. Education also provided to reoffer baths later, in the event of a refusal. Complete baths will be offered no less than twice weekly 4. Evaluate bathing records weekly for 3 months. Review in QA and revise the devised plan if indicated.	

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F 677	Continued From page 7 physical help of one (1) individual with bathing. Resident #2's diagnoses included, but were not limited to: high blood pressure, thyroid disorder, lung disease, and macular degeneration. Review of Resident #2's bathing documentation indicated, for two weeks of the resident's stay, the resident only had one bath/shower documented for each week. The first week, when only one bath was provided, was 12/22/2019 through 12/28/2010. The second week, when only one bath was provided, was 12/29/2019 through 1/4/2020. Resident #2's was care planned for the problem of "(resident name omitted) requires assistance with (activities of daily living related to) weakness" with the approach of "(a)ssist with (activities of daily living) as needed". This problem and approach was both documented on 12/30/2019. The facility's policy/procedure titled "Bath, Shower/Tub" (revised February 2018) was reviewed. This policy/procedure included the following information: "The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin." This policy/procedure did not detail the frequency at which a resident should be provided a bath/shower. During an interview on 10/5/2020 at 11:08 a.m., the facility's director of nursing (DON) stated the facility did not have a written policy that detailed the frequency for residents to receive a shower/bath but the DON reported the facility's goal was the resident receive two (2) baths per week. The DON stated facility staff would honor	F 677		

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F 677	Continued From page 8 residents' wishes related to bathing and showers. The facility's Administrator, Director of Nursing (DON), and Traveling DON were interviewed on 10/13/2020 at 4:00 p.m. During this interview, Resident #2's documentation of only receiving one (1) bath/shower per week on two (2) separate weeks was discussed. 2. The facility staff failed to ensure Resident #3's shower/bathing needs were consistently addressed. Resident #3's diagnoses included, but was not limited to: heart failure, anxiety, lung disease, and chronic pain. Resident #3's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 1/19/2020, had the resident assessed as frequently having pain at a "moderate" level. The resident was assessed as having a "dependence on supplemental oxygen". Resident #3 was assessed as requiring extensive assistance of one individual with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #3 was assessed as being totally dependent on one (1) individual for bathing. Review of Resident #3's clinical documentation revealed documentation of two showers/baths per week for most the resident's stay at the facility. The exception was the following three weeks: (1) January 19, 2020 through January 25, 2020; (2) March 1, 2020 through March 7, 2020; and (3) March 15, 2020 through March 21, 2020. For January 19, 2020 through January 25, 2020, one (1) shower was documented with no documentation of Resident #3 refusing a bath/shower. For March 1, 2020 through March	F 677		

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F 677	Continued From page 9 7, 2020 and March 15, 2020 through March 21, 2020, each week had one (1) shower documented and one (1) resident refusal of a bath/shower. On 10/23/2020 at 11:00 a.m., Resident #3's aforementioned shower documentation was discussed with the facility's Administrator and DON. 3. The facility staff failed to ensure Resident #1's shower/bathing needs were consistently addressed. Resident #1's admission minimum data set (MDS) assessment had the resident assessed as able to make self understood and able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) score was documented as a 12 out of 15. Resident #1 was documented as requiring extensive assistance of two (2) or more individuals with bed mobility, transfers, and toilet use. Resident #1 was assessed as requiring physical help of one (1) individual with bathing. Resident #1's diagnoses included, but were not limited to: heart failure, high blood pressure, diabetes, and chronic pain. Resident #1's documentation, for the week of March 1, 2020 through March 7, 2020, indicated the resident was provided one (1) bath/shower during the week. This was documented as a shower occurring on March 2, 2020. Resident #1's bathing documentation was reviewed with the facility's Director of Nursing (DON) on 10/5/2020 at 2:25 p.m., no additional information related to this finding was provided to the surveyor.	F 677		

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F 677	Continued From page 10 During an interview, on 10/16/2020 at 10:10 a.m., with the facility's Administrator and Director of Nursing (DON), the aforementioned shower/bathing documentation was discussed. 4. The facility staff failed to ensure Resident #4's shower/bathing needs were consistently addressed. Resident #4's admission minimum data set (MDS) assessment has the resident assessed as able to make self understood and as usually able to understand others. Resident #4's Brief Interview for Mental Status had the resident scored as a three (3) out of 15. Resident #4 was assessed as requiring supervision and one (1) person assistance with bed mobility, transfer, and personal hygiene. Resident #4 was assessed as requiring physical help of one (1) individual with bathing. Resident #4's diagnoses included, but were not limited to: high blood pressure, diabetes, arthritis, dementia, and lung disease. Review of Resident #4's bathing documentation revealed the following: - During two (2) weeks of January 2020, Resident #4 was not documented as being bathed or showered. - During two (2) weeks of February 2020, Resident #4 was not documented as being bathed or showered. - During the first four (4) weeks of March 2020, Resident #4 was documented as receiving one (1) shower during each week. - During the month of August 2020, Resident #4 was documented as receiving one (1) partial bed bath one (1) week and as receiving one (1) shower per week for two (2) weeks. (This would equal three (3) weeks where Resident #1 was	F 677		

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F 677	Continued From page 11 documented as only receiving (1) shower or bath per week.) - During the month of September 2020, Resident #4 was documented as receiving one (1) partial bed bath during one (1) week and as receiving one (1) shower during another week. (This would equal two (2) weeks where Resident #1 was documented as only receiving (1) shower or bath per week.) The facility's Administrator, Director of Nursing (DON), and Traveling DON were interviewed on 10/13/2020 at 4:00 p.m. During this interview, Resident #4's shower aforementioned bathing/shower documentation indicating the resident had, at times, received fewer than two (2) baths/showers per week was discussed. This is a complaint deficiency.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on interviews, the review of documents, and during the course of a complaint investigation, it was determined the facility staff	F 679	1. Resident # 2 was discharged on 1/14/20. 2. Any resident has the potential to be affected by the deficient practice. Audit performed of current residents to ensure that each one has an individualized activities plan. 3. Education provided to the Activity Director regarding the development of an activities plan for residents. New residents will be assessed within 7 days for activities needs/desires and plan of care implemented. 4. Perform audits weekly for 3 months to ensure activities assessments and plan of care has been developed within 7 days.	

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F 679	Continued From page 12 failed to address the activity needs and/or desires of one (1) of six (6) sampled residents (Resident #2). The findings include: The facility staff failed to develop and implement an activities plan for Resident #2. Resident #2's admission minimum data set (MDS) assessment had the resident assessed as able to make self understood and able to understand others. Resident #2's Brief Interview of Mental Status was scored as an eight (8) out of 15. Resident #2 was assessed as requiring limited assistance of one (1) individual with bed mobility, transfer, dressing, toileting, and personal hygiene. Resident #2's diagnoses included, but were not limited to: high blood pressure, thyroid disorder, lung disease, and macular degeneration. Resident #2's activity preferences assessment indicated it was very import for the resident to have reading material, listen to music, to keep up with the news, and to participate in religious services/practices. Review of Resident #2's clinical documentation failed to reveal evidence of the facility staff developing an activities care plan for Resident #2. Review of Resident #2's clinical documentation failed to reveal documentation of the resident participating in formal activities at the facility. On 9/29/2020 at 1:22 p.m., the facility's current Activities Director (AD) was interviewed about Resident #2's involvement in activities while at the facility. The AD reported he/she was not the activities director when Resident #2 was at the facility. The current AD reported he/she did not	F 679		

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F 679	Continued From page 13 see document of an activity care plan for Resident #2. The current AD reported he/she was unable to find documentation of Resident #2's involvement in activities while at the facility. The facility's Administrator, Director of Nursing (DON), and Traveling DON were interviewed on 10/13/2020 at 4:00 p.m. During this interview, the failure of facility staff members to develop and implement an activities plan for Resident #2 was discussed. This is a complaint deficiency.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews, the review of documents, and during the course of a complaint investigation, it was determined the facility staff failed to provide treatment and care in accordance with the comprehensive person-centered care plan for medications as ordered for one (1) of six (6) sampled residents (Resident #1). The findings include:	F 684	1. Resident # 1 was discharged on 3/21/20. 2. Any resident receiving medications has the potential to be affected by the deficient practice. An audit was performed to identify that new orders received were implemented. 3. Licensed nursing staff received education to ensure medications are administered according to the provider's order. 4. New orders will be reviewed weekly and compared to administration for 3 months.	

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F 684	Continued From page 14 Facility staff members failed to ensure Resident #1's medications were administered according to provider orders. Resident #1's admission minimum data set (MDS) assessment had the resident assessed as able to make self understood and able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) score was documented as a 12 out of 15. Resident #1 was documented as requiring extensive assistance of two (2) or more individuals with bed mobility, transfers, and toilet use. Resident #1 was assessed as requiring physical help of one (1) individual with bathing. Resident #1's diagnoses included, but were not limited to: heart failure, high blood pressure, diabetes, and chronic pain. Resident #1's clinical documentation included a nursing progress note dated 3/3/2020 at 10:51 a.m. This note included the following information: "Resident lying in bed, HOB elevated. Family at bedside visiting. Resident noted with nausea and vomiting, new orders given for Zofran 4mg PO q6hrs PRN for nausea and vomiting. A&Ox3. Skin warm and dry, (respirations) even and non-labored ... Will continue to monitor for nausea and vomiting ..." No documentation was found to indicate the resident had been administered the newly ordered Zofran. LPN #5, who cared for Resident #1 on this date, was interviewed via telephone. LPN #5 was able to remember providing Resident #1 with Zofran due to nausea. LPN #5 reported the Zofran was available in the facility's computerized medication dispensing cabinet. LPN #5 was unable to recall issues with the timing of Resident #1 Zofran administration.	F 684		

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F 684	Continued From page 15	F 684		

Resident #1's medication administration records (MARs) included an entry dated 3/3/2020 at 4:55 p.m. that stated the resident refused a medication due to vomiting. A nursing progress note dated 3/3/2020 at 5:56 p.m. stated: "Resident administered (as needed) Zofran at this time for nausea, resident with no further vomiting episodes at this time ..." This administration of the Zofran was not found documented on Resident #1's MARs.

Resident #1's clinical documentation included a nursing progress note dated 3/3/2020 at 8:50 p.m. This note read as follows: "Resident complaints of nausea. (Adult child) at bedside concerned about increased temp. Temp 101.4 (axillary). Gave PRN medication per orders. Resident has wheezing noted. Received new orders for CBC, CMP, and Chest x-ray." This note did not document what 'as needed' medication had been administered and at what dose. No evidence of an 'as needed' medication being administered at this time was found on Resident #1's MARs.

Resident #1's clinical documentation included a nursing progress note dated 3/3/2020 at 11:46 p.m. This note read as follows: "residents family requested staff takes residents temperature, obtained 100.9. administered (as needed) Tylenol. Rechecked residents [sic] temp 45 min later and obtained 98.9. Spoke with team health obtained order to obtain chest x-ray and labs on resident in AM. RP (responsible party) in room and aware of orders". This note did not identify what dose of Tylenol was administered. No documentation was found of this Tylenol administration being documented on the resident's MAR. During an interview on

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F 684	Continued From page 16 10/22/2020 at 10:14 a.m., the facility's DON confirmed Resident #1 did not have standing orders signed by a provider therefore Resident #1 did not have provider orders for the aforementioned Tylenol administration. The failure of facility staff to administer Resident #1's as needed (PRN) Zofran as ordered by the provider was discussed during an interview, on 10/16/2020 at 10:10 a.m., with the facility's Administrator and Director of Nursing (DON). During this same interview, the administration of Tylenol to Resident #1 without a provider order was discussed. This is a complaint deficiency.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receivesone is assessed for removal of the catheter assoon	F 690		

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F 690	Continued From page 17 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interviews, the review of documents, and during the course of a complaint investigation, it was determined the facility staff failed to receive services and assistance to maintain continence by implementing a scheduled toileting plan for one (1) of six (6) sampled residents (Resident #1). The findings include: Facility staff failed to implement a scheduled toileting intervention that was care planned to address Resident #1's bowel and bladder incontinence. Resident #1's admission minimum data set (MDS) assessment had the resident assessed as able to make self understood and able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) score was documented as a 12 out of 15. Resident #1 was documented as requiring extensive assistance of two (2) or	F 690	1. Resident # 1 was discharged on 3/21/20. 2. Any resident with incontinence has the potential to be affected by the deficient practice. Audit performed to validate that implementation has occurred for residents with a scheduled toileting intervention. 3. Licensed nursing staff educated to ensure a toileting program is implemented if placed in the resident's plan of care. 4. Select care plans will be audited weekly for 3 months to identify the presence of scheduled toileting interventions and appropriate implementation.	

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F 690	Continued From page 18	F 690		

more individuals with bed mobility, transfers, and toilet use. Resident #1's diagnoses included, but were not limited to: heart failure, high blood pressure, diabetes, and chronic pain.

A nursing assessment documented within the first two days of Resident #1's stay at the facility included the following information: (1) the resident was placed on a toileting program or trial with toileting schedule initiated, (2) the resident was always incontinent of urine, and (3) the resident was always incontinent of bowel. Resident #1's admission MDS assessment had the resident assessed as having occasional urinary incontinence and frequent bowel incontinence.

Resident #1's clinical documentation included a Baseline Care Plan for the resident's admission that had the resident documented as incontinent of bowel and bladder with the use of incontinence briefs or pads. This Baseline Care Plan also included 'scheduled toileting' for a bowel and bladder intervention but no specific times for the scheduled toileting had been documented. No documentation of the facility staff implementing the scheduled toileting program was found.

The failure of the facility staff to implement Resident #1's scheduled toileting intervention was discussed with the facility's Administrator and Director of Nursing (DON) on 10/16/2020 at 10:10 a.m.

During an interview on 10/26/2020 at 2:35 p.m., the DON reported he/she had spoken to the staff member who developed Resident #1's Initial/Baseline Care Plan. The DON stated this staff member reported that prompted toileting had

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F 690	Continued From page 19 been attempted every two (2) hours for the resident but had been unsuccessful. The DON reported the every two (2) hour, unsuccessful, attempts at toileting had not been documented. The DON reported that Resident #1 would not have been an appropriate candidate for a toileting plan. The DON referenced a "Bowel/Bladder Retraining Potential" document that indicated Resident #1 had "no improvement" with urinary incontinence after the toileting program trial; this document also reported the resident was "never aware" of toileting needs. This "Bowel/Bladder Retraining Potential" document was based on observations timed at 2:40 a.m. on the morning after the resident was documented as arriving at the facility. (Resident #1 was documented as arriving at the facility at 6:45 p.m. The resident was at the facility approximately eight (8) hours prior to the completion of the aforementioned "Bowel/Bladder Retraining Potential" document.) The following information was found in a facility policy titled "Behavioral Programs and Toileting Plans for Urinary Incontinence" (revised October 2010): "Habit Training/Scheduled Voiding 1. Habit Training/Scheduled Voiding is a technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident's voiding habits.....3. Habit training included timed voiding with the interval based on the resident's usual voiding schedule or pattern ... 5. Residents who cannot self-toilet may be candidates for habit training or scheduled voiding programs." This is a complaint deficiency.	F 690		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		

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F 755	Continued From page 20 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 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 interviews, review of documents, and during the course of a complaint investigation, it was determined the facility staff failed to ensure that routine and and/or emergency drugswere	F 755	1. Resident # 3 was discharged on 3/27/20. 2. Current residents audited for presence of pain medication orders and availability of medication. Any resident with pain medication orders has the potential to be affected by the deficient practice. 3. Licensed nursing staff educated to reorder pain medications timely to ensure availability. 4. Medication cart audits will be performed weekly for 3 months to ensure availability of pain medications.	

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F 755	Continued From page 21 available for one (1) of six (6) sampled residents (Resident #3). The findings include: The facility staff failed to ensure a pain medication (Oxycodone 30 mg) was available to be administered as ordered for Resident #3. Resident #3's diagnoses included, but was not limited to: heart failure, anxiety, lung disease, and chronic pain. Resident #3's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 1/19/2020, had the resident assessed as frequently having pain at a "moderate" level. The resident was assessed as having a "dependence on supplemental oxygen". Resident #3 was assessed as requiring extensive assistance of one individual with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #3's medication orders included an order for oxycodone tablet 30 mg one (1) tablet every four (4) hours. This order was scheduled for 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. This order had a start date of 1/28/2020 and a discontinue date of 2/17/2020. The following information as found documented in Resident #3's clinical record: - On 1/31/2020 at 12:00 a.m., it was documented the nurse contacted the facility's pharmacy in an attempt to access the aforementioned medication for Resident #3. Due to the way the medication would have to be dispensed, the pharmacy staff required a new order from the resident's provider. This note indicated a provider was contacted but	F 755		

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instructed for the medication to be held "due to resident's overall medication orders and (the resident) not having current complaint of pain".
- On 1/31/2020 at 3:38 a.m., it was documented a provider was again contacted about the medication not being available for the 4:00 a.m. dose. It was documented the provider "suggest we hold this dose also." The resident was documented as not complaining of pain at this time.
- On 1/31/2020 at 4:33 a.m., it was documented the resident was requesting pain medication. This note included the following information: "will give dose of (as needed) roxanol drops until oxycodone supply is available."

During an interview on 10/1/2020 at 2:47 p.m., the facility's director of nursing (DON) confirmed that Resident #3 did not receive two (2) doses of the ordered oxycodone 30 mg on 1/31/2020; Resident #3 did not receive the 12:00 a.m. dose and the 4:00 a.m. dose. The DON reported provider notification of the medications not being available was found in the aforementioned nursing notes but verbal orders to hold the two (2) doses were not entered.

Resident #3's Care Plan included a plan for the problem of "(resident's name omitted) has chronic pain." One of the 'approaches' listed was "Administer medications as ordered". This care plan was dated on 1/15/2020.

On 10/23/2020 at 11:00 a.m., the failure of the facility staff to ensure Resident #3's aforementioned medication was available was discussed with the facility's Administrator and DON.

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F 755	Continued From page 23 This is a complaint deficiency.	F 755		
F 842 SS=E	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	F 842	1. Resident #1 was discharged 3/21/20. Resident #2 was discharged 1/14/20. Resident #3 was discharged 3/27/20. Resident #4 currently resides in the facility. Resident #4 had an audit and completion of personal belongings observation on 10/14/20. 2. Any resident has the potential to be affected by the deficient practice. 1a. Audit of current residents performed to ensure orders are in place for held medications. Audit of current residents performed to ensure O2 administration is documented on the administration record. 1b. Audit of current residents performed to ensure orders are in place for held medications. 2. Audit of current residents performed to ensure orders are transcribed on the MAR for held medications 3. Perform audit of administration compliance report for documentation of late administrations. 4. Audit current residents record's for presence of personal belongings inventory. 3. 1a. Nurses educated to ensure that written orders are in place to hold any medication. Nurses educated to ensure that oxygen administered pm is documented on the MAR. 1b. Nurses educated to ensure that written orders are in place to hold any medication. 2. Nurses educated to enter verbal orders prior to administration of medications. 3. Nurses educated to document in MAR immediately following medication administration. 4. Direct care staff educated to perform and document an inventory of personal belongings upon admission, and update inventory with changes 4. 1a. Perform weekly audit for 3 months	

			of administration compliance report to ensure medications that were held have a corresponding provider's order. Perform weekly audit for 3 months of resident's using oxygen prn to ensure documentation on the MAR. 2. Perform weekly audit for 3 months of progress notes to identify documentation of verbal orders have a corresponding order on the MAR. 3. Perform weekly audit for 3 months to identify documentation of late medication administration. 4. Perform weekly audit for 3 months to ensure new admissions have personal inventory documented.	

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F 842	Continued From page 24 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §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 interviews, review of documents, and during the course of a complaint investigation, it was determined the facility staff failed to ensure complete and accurate clinical records for four (4) of six (6) sampled residents (Resident #1, Resident #2, Resident #3, and Resident #4). The findings included:	F 842		

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F 842	Continued From page 25 1A. The facility staff failed to ensure Resident #3's clinical record included the documentation of medication hold orders. The facility staff failed to ensure Resident #3's oxygen use was accurately and completely documented. Resident #3's diagnoses included, but was not limited to: heart failure, anxiety, lung disease, and chronic pain. Resident #3's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 1/19/2020, had the resident assessed as frequently having pain at a "moderate" level. The resident was assessed as having a "dependence on supplemental oxygen". Resident #3 was assessed as requiring extensive assistance of one individual with bed mobility, transfers, dressing, toilet use, and personal hygiene. The facility's policy titled "Charting and Documentation" (revised July 2017) included the following information: "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care." Resident #3's clinical documentation included an order for oxygen via nasal cannula at four (4) liters as needed for dyspnea. An area was included on the resident's medication administration records (MARs) to document when the oxygen was used. Resident #3's MARs documented that oxygen was only used for	F 842		

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	495425	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE REHAB CENTER AT BRISTOL	109 VILLAGE CIRCLE BRISTOL, VA 24201

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F 842	Continued From page 26 Resident #3 on 3/26/2020 at 7:13 p.m.; this documentation was confirmed by the director of nursing (DON) on the afternoon of 10/2/2020. The DON reported Resident #3's nursing progress notes included additional oxygen administration documentation. Resident #3's History and Physical (H&P) documented on 1/16/2020 included the following: "Patient is a (age and gender omitted) with a past medical history of COPD with chronic respiratory failure and hypercapnia who is oxygen dependent ..." During an interview on 10/2/2020 at 3:35 p.m., the facility's Family Nurse Practitioner(FNP) reported that 'oxygen dependent' meant the resident would need oxygen continuously. The FNP reported at times the resident would remove his/her oxygen. The FNP stated Resident #3 was observed most of the time with oxygen in use. The FNP stated that they would at times have to reposition the nasal cannula due to the resident removing it. On 10/23/2020 at 11:00 a.m., the failure of the facility staff to ensure Resident #3's oxygen administration was accurately documented on the resident's MARs was discussed with the facility's Administrator and DON. 1B. The facility staff failed to ensure provider verbal orders to not administer two (2) doses of Resident #3's pain medication were correctly documented. The following information as found documented in Resident #3's clinical record: - On 1/31/2020 at 12:00 a.m., it was documented the nurse contacted the facility's pharmacy in an attempt to access the aforementioned medication	F 842		

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F 842	Continued From page 27 for Resident #3. Due to the way the medication would have to be dispensed, the pharmacy staff required a new order from the resident's provider. This note indicated a provider was contacted but instructed for the medication to be held "due to resident's overall medication orders and (the resident) not having current complaint of pain". - On 1/31/2020 at 3:38 a.m., it was documented a provider was again contacted about the medication not being available for the 4:00 a.m. dose. It was documented the provider "suggest we hold this dose also." The resident was documented as not complaining of pain at this time. The two (2) aforementioned verbal orders to hold Resident #3's pain medication was not found documented as part of Resident #3's provider orders. During an interview on 10/1/2020 at 2:47 p.m., the facility's director of nursing (DON) confirmed that Resident #3 did not receive two (2) doses of the ordered oxycodone 30 mg on 1/31/2020; Resident #3 did not receive the 12:00 a.m. dose and the 4:00 a.m. dose. The DON reported verbal orders to hold the two (2) doses had not been entered. The following information was found in a facility policy titled "Telephone Orders" (revised February 2014): "Verbal telephone orders may be accepted from each resident's [sic] Attending Physician ... 1.....Orders must be reduced to writing, by the person receiving the order, and recorded in the resident's medical record.....3. Telephone orders must be countersigned by the physician during his or her next visit...."	F 842		

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F 842	Continued From page 28 On 10/23/2020 at 11:00 a.m., the failure offacility staff members to correctly document verbal orders to hold two (2) doses of a medication for Resident #3 was discussed with the facility's Administrator and DON. 2. Facility staff members failed to ensure Resident #1's medications administration records and provider verbal orders were completely and accurately documented. Resident #1's admission minimum data set (MDS) assessment had the resident assessed as able to make self understood and able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) score was documented as a 12 out of 15. Resident #1 was documented as requiring extensive assistance of two (2) or more individuals with bed mobility, transfers, and toilet use. Resident #1 was assessed as requiring physical help of one (1) individual with bathing. Resident #1's diagnoses included, but were not limited to: heart failure, high blood pressure, diabetes, and chronic pain. Resident #1's clinical documentation included a nursing progress note dated 3/3/2020 at 10:51 a.m. This note included the following information: "Resident lying in bed, HOB elevated. Family at bedside visiting. Resident noted with nausea and vomiting, new orders given for Zofran 4mg PO q6hrs PRN for nausea and vomiting. A&Ox3. Skin warm and dry, (respirations) even and non-labored ... Will continue to monitor for nausea and vomiting ..." No documentation was found to indicate the resident had been administered the newly ordered Zofran. Resident #1's provider orders failed to provide evidence of the aforementioned verbal order for Zofran being	F 842		

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F 842	Continued From page 29 entered into the resident's orders. An as needed order for Zofran was entered on 3/3/2020 at 5:50 p.m. Resident #1's medication administration records (MARs) included an entry dated 3/3/2020 at 4:55 p.m. that stated the resident refused a medication due to vomiting. A nursing progress note dated 3/3/2020 at 5:56 p.m. stated: "Resident administered (as needed) Zofran at this time for nausea, resident with no further vomiting episodes at this time ..." The administration of the Zofran was not found documented on Resident #1's MARs. Resident #1's clinical documentation included a nursing progress note dated 3/3/2020 at 8:50 p.m. This note read as follows: "Resident complaints of nausea. (Adult child) at bedside concerned about increased temp. Temp 101.4 (axillary). Gave PRN medication per orders. Resident has wheezing noted. Received new orders for CBC, CMP, and Chest x-ray." This note did not document what 'as needed' medication had been administered and at what dose. No evidence of a medication being administered at this time was found on Resident #1's MARs. Resident #1's clinical documentation included a nursing progress note dated 3/3/2020 at 11:46 p.m. This note read as follows: "residents family requested staff takes residents temperature, obtained 100.9. administered (as needed) Tylenol. Rechecked residents [sic] temp 45 min later and obtained 98.9. Spoke with team health obtained order to obtain chest x-ray and labs on resident in AM. RP (responsible party) in room and aware of orders". This note did not identify	F 842		

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F 842	Continued From page 30 what dose of Tylenol was administered. No documentation was found of the Tylenol administration being documented on the resident's MAR. During an interview on 10/22/2020 at 10:14 a.m., the facility's DON confirmed Resident #1 did not have standing orders signed by a provider therefore Resident #1 did not have provider orders for the aforementioned Tylenol administration. During an interview, on 10/16/2020 at 10:10 a.m., with the facility's Administrator and Director of Nursing (DON), the failure of facility staff members to maintain Resident #1's clinical documentation in a complete and accurate manner was discussed. This included this staff members' failure to document medications administered to Resident #1 on the resident's MAR. The failure of a facility staff member to documents which PRN (as needed) medication was administered on 3/3/2020 at 8:50 p.m. was also discussed during this interview. 3. The facility staff failed to ensure Resident #2's medication administration was documented in a timely manner. Resident #2's diagnoses included, but were not limited to: high blood pressure, lung disease, cardiac dysrhythmia, and gastro-esophageal reflux disease. Resident #2's minimum data set (MDS) assessment, with an assessment referenced date (ARD) of 12/21/2019, had the resident assessed as only requiring set-up and supervision with eating. The resident was not assessed as requiring physician assistance with eating. Resident #2 was assessed as having adequate hearing, clear speech, and as being able to make self understood.	F 842		

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F 842	Continued From page 31 Review of Resident #2's medication administration records (MARs) for the first week of January 2020 revealed that on 1/3/2020 the resident's 9:00 p.m. medications were not documented as being given until 10:57 p.m. The documentation indicated four (4) medications were "given" but "Charted Late". This documentation did not explicitly document if the medications was given on time or given late. On 10/13/2020 at 8:45 a.m., the facility's Director of Nursing (DON) confirmed that documentation of medication administration should be completed immediately after the medication is administered and prior to beginning another work task. The facility policy titled "Documentation of Medication Administration" (revised April 2007) included the following statement: "Administration of medication must be documented immediately after (never before) it is given." The facility's Administrator, Director of Nursing (DON), and Traveling DON were interview on 10/13/2020 at 4:00 p.m. During this interview, the failure of facility staff to correctly and/or completely document Resident #2 medication administration on the resident's MAR was discussed. 4. The facility staff failed to ensure Resident #4's personal belongings were inventoried and documented at the time of the resident's admission. Resident #4's admission minimum data set (MDS) assessment had the resident assessed as able to make self understood and as usually able	F 842		