STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495361	A. BUILDING _____ B. WING _____	03/05/2020

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ENVOY OF WOODBRIDGE, LLC	14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3/3/20 through 3/5/20. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 3/3/20 through 3/5/20. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 120 certified bed facility was 97 at the time of the survey. The survey sample consisted of 37 current Resident reviews (Residents 1 through 41) and 4 closed record reviews (Residents 9, 15, 19 and 30).	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550		4/14/20

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

Electronically Signed | 03/25/2020

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F 550	Continued From page 1 promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to promote resident dignity for two of 41 residents in the survey sample, Residents # 82 and # 43. During the lunch meal service on 3/3/2020 Resident #82 and #43, did not receive their meal for approximately 19 minutes, after staff served the five other residents seated at the same table, and the residents were eating their meals.	F 550	1. Resident #82 and #43 are being served meals at the same time as others sitting during the meal. 2. Dietary Manager educated to send tray for dining to ensure residents are served meals at the same time. 3. Nursing staff educated by Director of Nursing or designee to alert dietary if trays are missing immediately and obtain a tray	

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F 550	Continued From page 2 The findings include: Resident # 82 was admitted to the facility with diagnoses that included but were not limited to: heart failure and swallowing difficulties. Resident # 82's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/14/2020, coded Resident # 82 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 82 was coded as requiring supervision and assistance with setup for eating. Resident # 43 was admitted to the facility with diagnoses that included but were not limited to: altered mental status and aphasia [1]. Resident # 43's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/10/2020, coded Resident # 43 as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition for making daily decisions. Resident # 43 was coded as independent and requiring assistance with setup for eating. On 03/03/2020 at 1:10 p.m., an observation of the lunch meal was conducted in the facility's first floor dayroom. Observation of the room revealed a long table in the center of the room with seven residents at the table for lunch. At 1:12 p.m., a ladder rack of lunch trays was brought to the room. Five of the seven residents seated at the table received lunch trays. Further observation revealed two staff members preparing the resident's meals by cutting their food if necessary, opening containers, uncovering cups, providing appropriate utensils and providing	F 550	to ensure residents have a tray to eat at the same time. Quality monitoring to be completed 3 times a week x 4 weeks to ensure residents are being served meals at the same time. Follow up based on findings. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	

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F 550	Continued From page 3	F 550		

assistance to residents who required it. Observation of Resident # 82 and # 43, who did not receive a meal tray, revealed that they were seated at the table without anything to eat or drink while the other five residents began eating independently or with assistance. At 1:25 p.m., Resident # 82 and # 43 were provided something to drink; a period of 13 minutes had passed since the other residents started eating. At 1:31 p.m., 19 minutes later, two lunch trays were brought to the room for Resident # 82 and # 43.

On 03/03/20 at 2:37 p.m., an interview was conducted with CNA [certified nursing assistant] # 3. When asked about serving meals to residents seated at the same table, CNA # 3 stated, "Everyone should be served at the same time." When asked about Resident # 82 and # 43 not receiving their meals at the same time as the other residents seated at the table, CNA # 3 stated that it had never happened before. When asked why it was important to serve all the residents at the same time that were seated at the table, CNA # 3 stated, "It could make them feel bed."

On 03/03/20 at 4:15 p.m., an interview was conducted with OSM [other staff member] # 2, dietary manager. When asked about Resident # 82 and # 43 not receiving their lunch meals at the same time other resident were served at the same table, OSM # 2 stated, "It's a dignity issue. You don't want someone eating and someone else watching. You want to ensure they don't seem like they are isolated."

On 03/04/2020 at approximately 4:13 p.m., an interview was conducted with Resident # 82, regarding how they felt when their lunch meal

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F 550	Continued From page 4 was not served as the same time as other residents seated at the same table, Resident # 82 stated that they could not remember it. On 03/04/2020 at approximately 4:14 p.m., an interview with Resident # 43 could not conducted due to their low cognitive status. The facility's policy "Resident's Rights and Responsibilities" documented in part, "To be treated in a manner and in an environment that maintains or enhances your dignity, and respect in full recognition of your individuality and privacy." On 03/05 at 10:44 a.m., an interview was conducted with ASM [administrative staff member] # 3, regional coordinator of nursing services. When asked what standards of practice the nursing staff follow ASM # 3 stated that they follow Perry & Potter and their policies. On 03/03/2020 at 5:20 p.m., ASM # 1, executive director, ASM # 2, director of nursing and ASM # 3, regional coordinator of nursing services, were informed of the above findings. No further information was provided prior to exit. References: [1] A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.)	F 580		4/14/20

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F 580	Continued From page 5 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580		

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F 580	Continued From page 6 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to immediately notify and consult the physician for a change in condition, for one of 41 residents in the survey sample, Resident #93. The facility staff identified an unstageable wound on Resident #93's left heel on 11/19/19, and failed to immediately notify and consult the physician and wound care nurse about the wound and treatment initiated, until 11/22/19. The findings include: A review of the facility policy, "Notification of Change in Condition" documented, "The nurse to notify the attending physician and Resident Representative when there is a(n): *Accident, *Significant change in the patient/resident's physical, mental, or psychosocial status, *Need to alter treatment significantly..." Resident #93 was admitted on 10/4/19; diagnoses include but are not limited to peripheral vascular disease, stricture of artery, occlusion and stenosis of right and left carotid arteries,	F 580	1. Resident #93 was not negatively affected by not received physician notification and treatment orders for three days to her left heel. 2. Skin sweep conducted by License Nursing staff to identify current residents with potential risk of skin breakdown. 1:1 education provided with Licensed nurse who failed to provide physician notification and treatment order for the wound she documented on the weekly skin sheet. 3. Education to License Nursing staff on assessing, reporting and obtaining treatment orders and MD notification when skin issues are identified. Quality Monitoring to be completed daily Mon-Fri x 4 weeks in morning clinical meeting to ensure new skin issues have a treatment, MD notification and documentation of any changes in skin integrity. Follow up based on findings. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	

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F 580	Continued From page 7	F 580		

stroke, and atherosclerosis of bilateral legs. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/28/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, toileting, and eating; extensive assistance for bed mobility, dressing, and hygiene; and was incontinent of bowel and bladder.

A review of the clinical record revealed a weekly skin assessment dated 11/19/19, which included outline figure drawings of the front and back of a human body. On the back drawing, the left heel area was circled and the word "unstageable" was written next to it. LPN (Licensed Practical Nurse) #6 signed the assessment.

Further review of the clinical record failed to reveal any notes, orders, assessments, wound description, physician, family, or wound nurse notification until 11/22/19.

On 3/04/20 at 6:04 PM, in an interview with LPN #6, when asked what was done about the wound once she identified it on 11/19/19, LPN #6 stated, "Treatment was already in progress. There was a treatment order in place for that already." A review of the November 2019 MAR/TAR (Medication Administration Record/Treatment Administration Record) and physician orders was conducted with LPN #6 and revealed there were no previous orders or treatments in place for the heel or evidence of any heel wound prior to 11/19/19. LPN #6 stated that what was documented (the notation of an unstageable heel wound on skin assessment dated 11/19/19) was not her handwriting even though she validated it was her signature on the assessment. LPN #6

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stated, "I looked at her skin and I did not see any area on her heel on that day. I did not write that (unstageable)." LPN #6 stated, "When we find an area, we do an SBAR (Situation-Background-Assessment-Recommendation), an incident report, call the doctor, call the family. LPN's are not supposed to stage a wound." When asked what is documented about a wound, she stated, "Document on the wound, that there is a wound or open area, and the site, measurements, if there is any drainage, describe the wound, color."

A skin assessment dated 11/22/19 was reviewed. This assessment was written and signed by RN #6 (Registered Nurse), the wound care nurse. This assessment also documented an unstageable wound identified on the left heel.

Further review of the clinical record revealed an SBAR (Situation, Background, Appearance, Review) note dated 1/22/19 by RN #6. This note documented the identification of a pressure ulcer as an unstageable, physician notification and initiation of treatment of skin prep and foam dressing daily.

A nurse's note dated 11/22/19, by RN #6 documented, "Resident has an unstageable pressure ulcer to the left heel. I informed residents nurse, floor supervisor, MD (medical doctor), RP (responsible party) and DON (Director of Nursing). SBAR, incident report, care plan, wound sheet and treatment orders have been written. Treatment consists of cleansing wound and skin prep daily. Will continue to monitor."

A Pressure Ulcer Record report was started on

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11/22/19 by RN #6, and documented the left heel wound as unstageable with black eschar with measurements of 1.5x1.6x0 (in centimeters).

On 3/05/20 at 11:08 AM, an interview was conducted with RN #6. RN #6 stated that she was in a meeting on 11/22/19 and "we were going over the weekly skin assessments and I was asked if I was notified that the resident had a wound, and I said no, and I went upstairs to check her heel because it was marked on the skin sheet for the 19th. I went upstairs, checked her heel, and saw that she, (Resident #93) did have a pressure ulcer to her heel and I came back and told them she did have a wound on her heel. I was asked how did I not know, and I said that there are no treatments ordered and there was nothing in the 24-hour report saying that there was a change in the skin condition."

On 3/05/20 at 11:29 AM, in an interview with CNA #4 (Certified Nursing Assistant), CNA #4 stated she had been working with resident since she was moved to the unit (10/24/19). She stated she normally works with the resident on the evening shift. When asked about bathing, CNA #4 stated that all bathing - showers, bed baths, and partial baths, include the feet. CNA #4 stated, "I look at her feet for change of skin condition." She stated she did not recall when she first saw a change in condition of the left heel. CNA #4 stated, "It was a small black spot on the heel. I reported it to the nurse. The first time I saw it, it was black."

A review of the CNA documentation logs for bathing revealed the resident had either bed baths or partial baths each day in the days preceding the 19th. There was no evidence in the clinical record of any CNA's reporting a

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F 580	Continued From page 10 change in skin condition identified during the baths. On 3/05/20 at 12:15 PM, in an interview with LPN #2, when asked about the process staff follows for assessing residents' skin, LPN #2 stated, "We have a weekly assessment for checking the skin. I like to do mine in the morning when the CNA gets the residents ready. We check for redness, bruises, or any open areas, or edema, anything new." LPN #2 was asked about the process staff follows if something new is identified, LPN #2 stated, "Right away let the unit manager know, call the MD (medical doctor), get a new order, let family know, let the wound nurse know." CNA #4 stated, "Document it in the weekly skin assessment book for the date I find it, on the resident chart in a nurse's note, and an incident report, SBAR, care plan." A review of the comprehensive care plan revealed one for "(Resident #93) has Peripheral Vascular Disease [PVD]" and included the interventions, "Monitor the extremities for s/sx (signs and symptoms) of injury, infection or ulcers" and "Monitor/document/report PRN (as-needed) any s/sx of skin problems related to PVD: Redness, Edema, Blistering, Itching, Burning, Bruises, Cuts, other skin lesions." On 3/5/20 at approximately 1:30 PM, ASM #1 (Administrative Staff Member, the Executive Director), ASM #2 (Director of Nursing) and ASM #3 (Regional Coordinator of Nursing Services) were made aware of the findings. No further information was provided by the end of the survey.	F 580		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies	F 607		4/12/20

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F 607	Continued From page 11 CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to implement the facility abuse policy for reporting an allegation of abuse for one of 41 residents in the survey sample, Resident #89. Resident #89 alleged a CNA (certified nursing assistant) had abused him causing a scratch on the left elbow that was bleeding on 2/21/2020 at 5:30 a.m. The facility staff did not report the allegation to the State Agency until 2/21/20 at 11:21 AM, approximately five hours and fifty-one minutes after the alleged abuse occurred. The findings include: Resident #89 was admitted to the facility on 8/22/19 with diagnoses that included but were not limited to: Parkinson's disease (slowly progressive neurological disorder) (1), congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys (2), dementia (progressive	F 607	1. Resident #89 was not affected by the untimely reporting of the allegation of abuse on 2/21/2020. The allegation of abuse was not substantiated. 2. The Executive Director was educated to ensure timely reporting occurs by the Regional Director of Clinical Services. 3. Staff re-educated by the Executive Director/Designee to report allegations of potential abuse to the Executive Director immediately to ensure timely reporting of allegations of abuse. Quality Monitoring completed monthly x 3 months to ensure Facility Reported incidents are reported timely. Follow up based on findings. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	

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state of mental decline, memory function and judgement) (3).

Resident #89's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/25/19, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. The resident was coded as requiring extensive assistance in bed mobility, transfers, dressing, locomotion on unit, toileting and personal hygiene; supervision in eating.

The facility policy, "Abuse, Neglect, Exploitation & Misappropriation" dated 11/28/17, documented in part, "Patients of the Center have the legal right to be free from verbal, sexual, mental and physical abuse. Obligated to report such information immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury."

A "Facility Reported Incident" (FRI) dated 2/21/20, documented in part, "Incident date: 2/21/20. Resident's involved (name of Resident #89). Injuries: Scratch on left elbow and knee scab. Incident type: Allegation of abuse/mistreatment. Describe incident: (name of Resident #89) has made allegation of abuse against a CNA (certified nursing assistant) while she was performing care.

The FRI per witness statement occurred at 5:30 AM on 2/21/20, and documented it was faxed on 2/21/20 at 11:21 AM) to the State Agency (Virginia Department of Health-Office Licensure / Certification), five hours and fifty-one minutes after the alleged abuse.

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	495361	A. BUILDING _____ B. WING _____	03/05/2020

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A nurse's progress note in Resident #89's clinical record dated 2/21/20, at 5:30 AM, documented in part, "While assisting resident, he became verbally and physically abuse towards staff, he scratched CNA. Afterward he was noted to have bleeding from right upper extremity and right lower extremity. Physician was notified, areas cleaned with bacitracin and dressing applied. Resident stated, [I might have injured the aide, but I don't care because she grabbed me first.]"

A review of the comprehensive care plan dated 9/16/19, documented in part, "Focus: Behaviors of poor impulse control and difficulty adjusting to new environment as evidenced by being physically aggressive towards staff." The "Interventions" documented and dated 9/16/19, "Analyze times of day, places, circumstances, triggers and what de-escalates behavior. Assess and address for contributing sensory deficits. When resident becomes agitated, guide away from source of distress, engage calmly in conversation; If response is aggressive, staff to walk away calmly and approach later."

An interview was conducted on 3/4/20 at 8:00 AM with Resident #89. When asked if he remembered the event on 2/21/20, Resident #89 stated, "Yes, the aide was rough with me getting me out of bed to the wheelchair. She grabbed me and my knee hit the wheelchair. I did not have my hearing aids in so maybe I did not hear what she was saying. I grabbed her back."

An interview was conducted on 3/5/20 at 7:59 AM with RN (registered nurse) #2, when asked what is abuse, RN #2 stated, "Abuse is physical, verbal, sexual, hitting/scratching, mental." When

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F 607	Continued From page 14 asked about the process staff follows for an allegation of abuse, RN #2 stated, "I would report to the supervisor right away, the director of nursing and to the executive director. I would inform the physician, and RP (responsible party)." An interview was conducted on 3/4/20 at 3:50 PM with ASM (administrative staff member) #2, the director of nursing. When asked the period for reporting abuse allegations to the State Agency, ASM #2 stated, "We report within two hours." ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional coordinator for nursing services, were made aware of the above concern on 3/4/20 at 6:40 PM. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 435. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 133. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 154.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		4/14/20

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F 609	Continued From page 15 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to report an allegation of abuse in a timely manner for one of 41 residents in the survey sample, Resident #89. On 2/21/2020 at 5:30 a.m., Resident #89 alleged a CNA (certified nursing assistant) had abused him causing a scratch on the left elbow that was bleeding, and was not reported to the State Agency until 2/21/20 at 11:21 AM, five hours and fifty-one minutes after the alleged abuse occurred. The findings include:	F 609	1. Resident #89 was not affected by the untimely reporting of the allegation of abuse on 2/21/2020. The allegation of abuse was not substantiated. 2. The Executive Director was educated to ensure timely reporting occurs by the Regional Director of Clinical Services. 3. Staff re-educated by the Executive Director/Designee to report allegations of potential abuse to the Executive Director immediately to ensure timely reporting of allegations of abuse. Quality Monitoring completed monthly x 3 months to ensure	

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F 609	Continued From page 16 Resident #89 was admitted to the facility on 8/22/19 with diagnoses that included but were not limited to: Parkinson's disease (slowly progressive neurological disorder) (1), congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys (2), dementia (progressive state of mental decline, memory function and judgement) (3). Resident #89's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/25/19, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. The resident was coded as requiring extensive assistance in bed mobility, transfers, dressing, locomotion on unit, toileting and personal hygiene; supervision in eating. A "Facility Reported Incident" (FRI) dated 2/21/20, documented in part, "Incident date: 2/21/20. Resident's involved (name of Resident #89). Injuries: Scratch on left elbow and knee scab. Incident type: Allegation of abuse/mistreatment. Describe incident: (name of Resident #89) has made allegation of abuse against a CNA (certified nursing assistant) while she was performing care. FRI per witness statement occurred at 5:30 AM on 2/21/20, and documented it was faxed on 2/21/20 at 11:21 AM) to the State Agency (Virginia Department of Health-Office Licensure / Certification), five hours and fifty-one minutes after the alleged abuse A nurse's progress note in Resident #89's clinical	F 609	Facility Reported incidents are reported timely. Follow up based on findings. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	

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record dated 2/21/20, at 5:30 AM, documented in part, "While assisting resident, he became verbally and physically abuse towards staff, he scratched CNA. Afterward he was noted to have bleeding from right upper extremity and right lower extremity. Physician was notified, areas cleaned with bacitracin and dressing applied. Resident stated, [I might have injured the aide, but I don't care because she grabbed me first.]"

A review of the comprehensive care plan dated 9/16/19, documented in part, "Focus: Behaviors of poor impulse control and difficulty adjusting to new environment as evidenced by being physically aggressive towards staff." The "Interventions" documented and dated 9/16/19, "Analyze times of day, places, circumstances, triggers and what de-escalates behavior. Assess and address for contributing sensory deficits. When resident becomes agitated, guide away from source of distress, engage calmly in conversation; If response is aggressive, staff to walk away calmly and approach later."

An interview was conducted on 3/4/20 at 8:00 AM with Resident #89. When asked if he remembered the event on 2/21/20, Resident #89 stated, "Yes, the aide was rough with me getting me out of bed to the wheelchair. She grabbed me and my knee hit the wheelchair. I did not have my hearing aids in so maybe I did not hear what she was saying. I grabbed her back."

An interview was conducted on 3/5/20 at 7:59 AM with RN (registered nurse) #2, when asked what is abuse, RN #2 stated, "Abuse is physical, verbal, sexual, hitting/scratching, mental." When asked about the process staff follows for an allegation of abuse, RN #2 stated, "I would report

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F 609	Continued From page 18 to the supervisor right away, the director of nursing and to the executive director. I would inform the physician, and RP (responsible party)." An interview was conducted on 3/4/20 at 3:50 PM with ASM (administrative staff member) #2, the director of nursing. When asked the period for reporting abuse allegations to the State Agency, ASM #2 stated, "We report within two hours." The facility policy, "Abuse, Neglect, Exploitation & Misappropriation" dated 11/28/17, documented in part, "Patients of the Center have the legal right to be free from verbal, sexual, mental and physical abuse. Obligated to report such information immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury." ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional coordinator for nursing services, were made aware of the above concern on 3/4/20 at 6:40 PM. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 435. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 133. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 154.	F 609		
F 645 SS=D	PASARR Screening for MD & ID	F 645		4/14/20

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F 645	Continued From page 19 CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission	F 645		

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F 645	Continued From page 20 to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to evidence an accurate PASARR (preadmission screening and resident review) screening for one of 41 residents in the survey sample, Resident #69. The facility failed to ensure an accurate PASARR was completed upon admission for Resident #69.	F 645	1. Resident #69 PASARR was updated and reflects the resident had serious mental illness on question #2. 2. Audit was completed on current residents in the facility to ensure PASARRs are completed accurately. Any findings that are not accurate will be completed accurately and placed in the	

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F 645	Continued From page 21 The findings include: Resident #69 was admitted to the facility on 4/26/19. Resident #69's diagnoses included but were not limited to: dementia (progressive state of mental decline, memory function and judgement) (1), bipolar disorder (mental disorder characterized by mania and depression) (2), psychosis (mental disorder with detachment from reality and impaired perceptions and thinking) (3). Resident #69's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/6/20, coded the resident as scoring 99 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was unable to complete the interview. MDS Section G- Functional Status: coded the resident as requiring extensive assistance in dressing, eating, toilet use, personal hygiene and bathing; limited assistance with bed mobility, walking in room/corridor and supervision with transfers. A review of Resident #69's clinical record revealed the resident's PASARR was completed prior to admission on 4/17/19. The PASARR Question #2 "Does the individual have a current serious mental illness" was incorrectly coded for Resident #69 as "No". On 3/4/20 at 2:30 PM and interview was conducted by telephone with OSM (other staff member) #1, the care liaison/admissions coordinator. When asked if Resident #69's diagnosis of bipolar disorder and psychosis were considered serious mental illnesses, OSM #1 stated, "Yes, they are both serious mental	F 645	medical record. 3. Admissions Director and Social Services educated by the Executive Director/Designee to ensure PASARRs are accurate from admission. Social Service Department will audit new admission charts for accurate PASARRs. Quality monitoring to occur daily Mon-Fr x 4 weeks in the morning clinical meeting to ensure new admission and re-admission residents have a complete and accurate PASARR. Follow up based on findings. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	

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F 645	Continued From page 22 illnesses." When asked why the PASARR Question #2 "Does the individual have a current serious mental illness" was coded as "No", OSM #1 stated, "If it is coded that way, it is incorrect and I will revise the form." The facility policy, "Pre-Admission Screening for Serious Mental Illness and Intellectually Disabled Individuals", dated 9/17, documented in part, "It is the responsibility of the center to assess and assure that the appropriate pre-admission screenings, are conducted and results obtained prior to admission." ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional coordinator for nursing services, were made aware of the above concern on 3/4/20 at 6:40 PM. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 154. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 133. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 480.	F 645		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans	F 655		4/14/20

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§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details

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F 655	Continued From page 24 of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined the facility staff failed to develop a baseline care plan for one of 41 residents in the survey sample, Resident #348. The facility failed to develop a baseline care plan to include and address the care of Resident #348's PICC (peripherally inserted central catheter). The findings include: Resident #348 was admitted to the facility on 2/21/20. Resident #348's diagnoses that included but are not limited to: cellulitis (inflammation of tissue) (1), diabetes mellitus (altered glucose metabolism caused by the inability of insulin to function normally in the body) (2) and chronic obstructive pulmonary disease (chronic non-reversible lung disease) (3). Resident #348's most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/21/20, coded the resident as scoring 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of Resident #348's baseline care plan dated 2/21/20 failed to document the presence or care of Resident #348's PICC line. The baseline care plan, 'Infection' section documented in part, "Right foot/heel infection." A review of the physician orders dated 2/21/20, documented in part, "Vancomycin (antibiotic) 1 gram in 250 milliliters of sodium chloride: activate and mix, infuse over 90 minutes."	F 655	1. The baseline care plan for resident #348 was updated to address the care of the PICC line. 2. Audit conducted of recent new admission baseline care plans was completed to ensure they are accurate and reflect the care of the resident. 3. License Nursing staff educated to update the baseline care plan upon admission and with any changes. Quality Monitoring to be completed daily Mon-Fri x 4 weeks in the morning clinical meeting to ensure residents baseline care plans are updated timely. Follow up based on findings. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	

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A review of the physician orders dated 2/26/20, documented in part, "Change PICC line dressing to left arm every week on 7:00 AM-3:00 PM shift, every Thursday.

An interview was conducted on 3/3/20 at 5:03 PM with LPN (licensed practical nurse) #1. When asked the purpose of the PICC line, LPN #1 stated, "The PICC is in place to deliver antibiotics for a longer period of time." When asked the purpose of the care plan, LPN #1 stated, "The care plan is based on the needs of the resident. It is where we document our actions based on orders and resident needs."

ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional coordinator for nursing services, were made aware of the above concern on 3/4/20 at 6:40 PM.

The facility's "Plans of Care" policy dated 9/25/17, documents in part, "Develop and implement an individualized person-centered baseline care plan within 48 hours of admission that includes, but not limited to, initial goals based on the admission orders, physician orders, dietary orders and therapy/social services."
No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 108.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 160.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and

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F 655	Continued From page 26 Chapman, page 120.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		4/14/20

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F 656	Continued From page 27 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview it was determined that the facility failed to ensure a complete and accurate medical record for one of 41 residents in the survey sample, Resident # 7. The facility staff failed to document the percentage of food eaten at meals for Resident #7. The findings include: Resident # 7 was admitted to the facility with diagnoses that included but were not limited to swallowing difficulties, amnesia, and adult failure to thrive. Resident # 7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/27/2020, coded Resident # 7 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being moderately impaired of cognition for making daily decisions. Resident # 7 was coded as independent and requiring assistance with setup for eating. Section K "Swallowing/Nutritional Status" coded Resident # 7 under K0300 Weight Loss, 2 [two] Yes, not on physician-prescribed weight-loss regimen." The comprehensive care plan for Resident # 7 with a revision date of 10/08/19 documented in part, "Focus. [Resident # 7] has potential	F 656	1. The care plan for resident #7 is being followed and meal percentage is being documented for each meal. 2. Audit completed for current resident meal intake percentages to ensure they are documented for each meal per their care plan. 3. CNA□s were educated by the Director of Nursing/Designee to ensure meal percentages are documented in POC for each meal. Quality Monitoring to be completed 5 times a week for 4 weeks to ensure meal percentages are documented in POC by CNA□s. Follow up based on findings. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	

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nutritional imbalance and risk for wt. [weight] fluctuation r/t [related to] Depression, Hx [history] of CVA [cerebral vascular accident] w/ [with] residual deficit and limited assist with weakness. Revision on 10/09/2018." Under "Interventions" it documented in part, "Provide, serve diet as ordered. Monitor intake and record q [every] meal. Date Initiated: 10/09/2018."

The facility's ADL [activities of daily living] record for Resident # 7 dated February 2020 documented, "ADL - Eating Meal Percentage. 0900 [9:00 a.m.] Day, 1300 [1:00 p.m.], Day, 1800 [6:00 p.m.] Evening." Further review of the ADL record failed to evidence documentation of meal percentages at 9:00 a.m. on the following dates:
02/01/2020,
02/03/2020 through 02/11/2020,
02/14/2020,
02/16/2020 through 02/23/2020,
02/25/2020 through 02/29/2020;
The ADL record failed to evidence documentation of meal percentages at 1:00 p.m., on the following dates:
02/01/2020,
02/03/2020 through 02/12/2020,
02/14/2020,
02/16/2020 through 02/23/2020,
02/25/2020 through 02/29/2020, and at 6:00 p.m. on 02/04/2020, 02/09/2020, 02/18/2020, 02/23/2020 and on 02/28/2020.

The facility's ADL record for Resident # 7 dated March 2020 documented, "ADL - Eating Meal Percentage. 0900 Day, 1300 Day, 1800 Evening." Further review of the ADL record failed to evidence documentation of meal percentages at 9:00 a.m. on 03/02/2020 through 03/04/2020; at

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1:00 p.m. on 03/02/2020 through 03/04/2020 and at 6:00 p.m. on 03/03/2020.

On 03/04/20 at 4:34 p.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked why it was important to document the amount of food a resident consumes at each meal, ASM # 2 stated to be able to track the amount of intake. After reviewing the missing documentation on the ADL record for Resident # 7 dated February and March 2020 for the dates listed above, ASM # 2 stated they would not be able to determine how much the resident is eating at her meals or any type of weight loss trend, (for Resident #7).

On 03/05/2020 at 10:44 a.m., an interview was conducted with ASM [administrative staff member] # 3, regional coordinator of nursing services. When asked what standards of practice the nursing staff follow ASM # 3 stated that they follow Perry & Potter and their policies.

Potter and Perry's Fundamentals of Nursing, 6th edition, page 477, reveals the following information: "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients."

On 03/04/2020 at 6:40 p.m., ASM # 1, executive director, ASM # 2, director of nursing and ASM #

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F 656	Continued From page 30 3, regional coordinator of nursing services, were informed of the above findings.	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to follow professional standards of practice for two of 41 residents in the survey sample, Residents #80 and #55. The facility staff failed to transcribe a physician order for Resident #80's bilateral knee braces accurately to the TAR (treatment administration record). The facility staff failed to clarify multiple as needed pain medication orders for Resident #55 to determine when and which medication to administer based on pain level parameters. The findings include: 1. Resident #80 was admitted to the facility on 4/24/19; with a recent readmission on 2/5/2020 with diagnoses that included but were not limited to end stage renal disease requiring hemodialysis [a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine.] (1), peripheral vascular disease [any abnormal condition, including atherosclerosis, affecting blood vessels outside the heart.] (2),	F 658	1. The order for the knee brace for resident #80 was clarified and written accurately on the March TAR. The order for resident #55 pain medication was clarified with parameters and transcribed to the MAR. 2. Audit completed for current residents with braces to ensure orders are transcribed accurately on the TAR. Audit completed for current residents with multiple pain medications to ensure parameters are in place and transcribed to the MAR. 3. Licensed Nurses educated to ensure current residents with braces have orders for skin assessments under the brace per physicians order and to ensure parameters are on pain medications if multiple pain medication are ordered. Quality monitoring to be done weekly x 4 weeks by Nursing/designee to ensure braces have orders for skin assessments on TAR per physician's orders and pain medications have parameters if multiple	4/14/20

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F 658	Continued From page 31 diabetes and bilateral tibia plateau fractures. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 2/12/2020 coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she was coded as independent after set up assistance was provided. The orthopedic consult dated 2/25/2020 documented, "NWB (non-weight-bearing). 2. Braces knee applied bilat (bilaterally) - skin precautions to prevent skin breakdown - may keep open when in bed." The above orders were documented in the clinical record as physician orders. The February TAR (treatment administration record) documented, "2/5/2020 - Apply knee immobilizer to bil (bilateral) knees at all times. May remove to assess skin integrity." This was signed off every day in the month of February. The TAR also documented, "2/25/2020 - Braces knee applied bilaterally; Skin precautions to prevent skin breakdown. May keep open when in bed." Next to this was handwritten, "Duplicate Order." A line was documented across the page and nothing was signed off. The March 2020 TAR documented, "Apply immobilizer to bilateral knees at all times - may remove to assess skin integrity." It was signed off	F 658	pain medications are ordered. Follow up based on findings. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	

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as completed every shift from 3/1/2020 through 3/4/2020. The order dated 2/25/2020 did not appear on the March TAR.

On 03/05/2020 at 10:44 a.m., an interview was conducted with ASM (administrative staff member) # 3, the regional coordinator of nursing services. When asked what standards of practice the facility follows, ASM # 3 stated that they follow Perry & Potter and their policies.

An interview was conducted with LPN (licensed practical nurse) #2 on 3/5/2020 at 12:15 p.m. The above order from the orthopedist and the February and March TARs were reviewed with LPN #2. When asked if the orders are the same orders, LPN #2 stated, "No, they are two different devices."

An interview was conducted with RN (registered nurse) #3, the MDS nurse, on 3/5/2020 at 12:44 p.m. The above orders from the orthopedist and the February and March 2020 TARs were reviewed with RN #3. When asked if the two orders are for the same thing, RN #3 stated, "They are not the same orders. They are two different orders." When asked if this is a transcription error, RN #3 stated, "Yes, I would say so."

The facility policy, "Physician Orders" documented in part, "The order is transcribed to all appropriate areas (MAR [mediation administration record] TAR, etc.) or electronic equivalent."

The nurse or a designated unit secretary writes the prescriber's complete order on the

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appropriate medication form, the MAR...When transcribing orders, the nurse should be sure that names, dosages and symbols are legible... A registered nurse checks all transcribed orders against the original order for accuracy and thoroughness."(3)

ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional coordinator of nursing services were made aware of the above concern.

No further information was obtained prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447.
(3) Fundamentals of Nursing 6th edition; Perry and Potter, page 846
2. Resident #55 was admitted to the facility on 2/20/20 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (chronic non-reversible lung disease) (1), rheumatoid arthritis (chronic destructive disease characterized by joint inflammation) (2) and carotid artery stenosis (abnormal narrowing of one or both of the main arteries that supply the brain) (3).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/28/20, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status

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coded the resident as requiring extensive assistance for toileting, supervision for eating and independent for bed mobility, dressing, personal hygiene, walking in room and locomotion on/off unit.

A physician order dated 2/19/20 documented, "Oxycodone [used to treat moderate to severe pain] (4) tablet 5 milligram every three hours as needed for pain.
A physician order dated 2/21/20 documented, "Tylenol [used to treat pain and fever] (5) 650 milligram every six hours for pain management.
A physician order dated 2/21/20 documented, "Morphine sulfate [used to treat moderate to severe pain] (6) 15 milligram tablet every four hours as needed for pain.

The February 2020 MAR (medication administration record), for Resident #55 documented the above physicians orders for the medications. The medications were administered to the resident on the following dates and times for the pain level ratings as follows:
Oxycodone 5 milligram:
2/22/20 at 04:00 AM - pain level - 8
2/22/20 at 10:00 AM - pain level - 7
2/22/20 at 2:00 PM- pain level - 7
2/22/20 at 6:00 PM- pain level - 7
2/22/20 at 10:00 PM- pain level - 7
2/23/20 at 10:00 AM- pain level - 7
2/23/20 at 2:00 PM- pain level - 7
2/23/20 at 6:00 PM- pain level - 7
2/23/20 at 10:00 PM- pain level - 7
2/24/20 at 5:00 AM- pain level - 8
2/24/20 at 9:00 AM- pain level - 10
2/24/20 at 4:00 PM- pain level - 7
2/24/20 at 7:00 PM- pain level - 7
2/24/20 at 10:00 PM- pain level - 8

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2/25/20 at 1:00 AM- pain level - 7
2/25/20 at 1:00 PM- pain level - 7
2/25/20 at 6:00 PM- pain level - 7
2/25/20 at 9:00 PM- pain level - 7
2/26/20 at 2:00 AM- pain level - 7
2/26/20 at 6:00 AM- pain level - 7
2/26/20 at 5:30 PM- pain level - 6
2/26/20 at 9:30 PM- pain level - 7
2/27/20 at 9:00 AM- pain level - 7
2/27/20 at 1:45 PM- pain level - 7
2/27/20 at 5:30 PM- pain level - 7
2/27/20 at 9:00 PM- pain level - 7
2/28/20 at 9:30 AM- pain level - 7
2/28/20 at 5:30 PM- pain level - 7
2/28/20 at 10:00 AM- pain level - 7
2/29/20 at 12:00 AM- pain level - 8
2/29/20 at 5:30 PM- pain level - 7
2/29/20 at 6:00 PM- pain level - 7

Morphine sulfate 15 milligram:
2/21/20 at 9:00 AM - pain level - 8
2/21/20 at 1:00 PM - pain level - 7

The resident's pain level, location and effectiveness were documented and non-pharmacological interventions were documented prior to administration of the medication.

The March 2020 MAR (medication administration record), for Resident #55 documented the above physicians orders for the medications. The medications were administered to the resident on the following dates and times for the pain level ratings as follows:
Oxycodone 5 milligram:
3/1/20 at 5:00 AM- pain level - 7
3/1/20 at 1:00 PM- pain level - 7
3/1/20 at 4:15 PM- pain level - 8

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3/2/20 at 1:00 PM- pain level - 7
3/2/20 at 5:00 PM- pain level - 7
3/2/20 at 10:00 PM- pain level - 7
3/3/20 at 10:30 AM- pain level - 5
3/3/20 at 4:50 PM- pain level - 8
3/3/20 at 9:30 PM- pain level - 5
3/4/20 at 1:30 PM- pain level - 7

Morphine sulfate 15 milligram:
3/1/20 at 8:30 AM- pain level - 8
3/2/20 at 8:45 AM- pain level - 8
3/2/20 at 9:00 PM- pain level - 7
3/4/20 at 00:30 AM- pain level - 8

The resident's pain level, location and effectiveness were documented and non-pharmacological interventions were documented prior to administration of medications.

The baseline care plan dated 2/20/20, documented in part, Problem: "Pain- Will maintain comfort to highest degree possible." The Interventions dated 2/20/20, documented, "Monitor for pain. Administer pain medications as ordered. Non-drug interventions. Eliminate or reduce causative factors."

The physician progress note dated, 2/21/20 at 10:30 AM, documented in part, "Patient assessed and evaluated. Pain medications were reviewed, continue as ordered."

On 3/3/20 at 5:03 PM, LPN (licensed practical nurse) #1 was observed administering pain medication to Resident #55. An interview was conducted with LPN #1, when asked Resident #55's pain level, LPN #1 stated, "It is an 8." LPN #1 was asked how staff determined which pain

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medication should be administered, LPN #1 stated, "She has been on pain medications for a long time, so she knows which one to ask for." When asked if her pain medication orders gave parameters for administration, LPN #1 stated, "No, these do not have parameters but we use mild, moderate and severe for pain levels." When asked if it within nursing scope of practice to decide which pain medications to administer, LPN #1 stated, "No, it is not within our scope to decide which pain medication to give. I will clarify these orders."

An interview was conducted on 3/3/20 at 5:10 PM with ASM #2, the director of nursing. When asked if the nursing scope of practice permitted nurses to determine which pain medication to administer, ASM #2 stated, "No, we should clarify the physician orders."

An interview was conducted with ASM #3, the regional coordinator of nursing services on 3/5/20 at 10:44 AM. When asked what standards of practice the facility follows, ASM # 3 stated, "We follow our policies and Perry & Potter."

ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional coordinator for nursing services, were made aware of the above concern on 3/4/20 at 6:40 PM.

The facility's "Physician Orders" policy dated 8/22/17, documents in part, "Admission orders: Information received from the referring facility to be reviewed and transcribed to the physician order form. The attending physician reviews and confirms the orders."

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F 658	Continued From page 38 According to Fundamentals of Nursing, 6th edition Potter and Perry, 2005, page 846, "A medication order is required for any medication to be administered by a nurse. If the medication order in incomplete, the nurse should inform the prescriber and ensure completeness before carrying out any medication order." No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 120. (2) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 507. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 103/541. (4) 2009 Lippincott Pocket Drug Guide for Nurses, Wolters Kluwer, page 448. (5) 2009 Lippincott Pocket Drug Guide for Nurses, Wolters Kluwer, page 4. (6) 2009 Lippincott Pocket Drug Guide for Nurses, Wolters Kluwer, page 253.	F 658		
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	F 684		4/14/20

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F 684	Continued From page 39 by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to provide treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan for two of 41 residents in the survey sample, (Residents # 4 and Resident #7). The facility staff failed to ensure Resident #4 received only nectar-thickened liquids per the physician orders. On 3/3/2020 during the lunch meal CNA (certified nursing assistant) # 3, was observed providing Resident # 4 two sips thin consistency juice by use of a straw. The facility staff failed to administer "Mighty House Shake" [liquid dietary supplement] to Resident # 7 according to the physician order. The findings include: 1. Resident # 4 was admitted to the facility with diagnoses that included but were not limited to: aphasia [1] and swallowing difficulties. Resident # 4's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/27/2020, coded Resident # 4 as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition for making daily decisions. Resident # 4 was coded as requiring extensive assistance of one staff member for eating. Section K "Swallowing/Nutritional Status" coded Resident # 4 as having a "Mechanically altered diet - require change in texture of food or liquids (e.g., pureed foods, thickened liquids)." On 03/03/2020 at 1:10 p.m., an observation of the	F 684	1. Resident #4 was not affected by receiving thin consistency liquids. Resident #7 was not affected by not following the physician's order for might shakes. 2. Audit completed for current residents on thickened liquids and mighty shakes to ensure they are receiving liquids as ordered and mighty shakes are being delivered on meal trays. 3. Education provided to dietary staff by Dietary Manager/Designee to ensure residents with thickened liquids and mighty shakes are on trays per physician's orders. Nursing Staff educated by Director of Nursing /Designee for staff to ensure the resident receives thicken liquids and mighty shakes as ordered. Quality monitoring to be completed 5 times a week x4 weeks to ensure thicken liquids and mighty shakes are served per physicians order. Follow up based on finding. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	

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lunch meal was conducted on the facility's first floor dayroom. Observations of Resident # 4 revealed they were sitting in their wheelchair at the table and CNA [certified nursing assistant] # 3 seated next to them. Observation of Resident # 4's lunch tray revealed that it contained pureed consistency food, thickened coffee and a cup of thin juice. Observation of CNA # 3 revealed they were feeding Resident # 4 their food and providing sips of liquids. Further observation of CNA # 3 revealed they gave Resident # 4 two sips of their thin consistency juice by use of a straw.

The speech therapy swallowing assessment for Resident # 4 dated 02/10/2020 documented in part, "Precautions Include: Pureed diet with Nectar thickened liquids."

The facility's dietary meal ticket for Resident # 4 documented in part, "Coffee or Tea. Nectar Thickened."

The comprehensive care plan for Resident # 4 with a revision date of 12/09/2019 documented in part, "Focus. [Resident # 4] is at risk for fluid imbalance & [and] dehydration r/t [related to] Dysphagia [swallowing difficulties] & Advanced Dementia. Revision on: 12/09/2019." Under "Interventions" it documented in part, "Provide NECTAR thickened liquids as ordered. Revision on: 8/28/2019."

On 03/03/20 at 2:37 p.m., an interview was conducted with CNA [certified nursing assistant] # 3. When asked about serving Resident # 4 thin consistency liquid during lunch CNA # 3 stated that Resident # 4 was suppose to have nectar thick liquids. When asked if Resident # 4's meal

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ticket documented the consistency for Resident # 4's liquids they stated yes. When asked why Resident # 4 was taking thickened liquids CNA # 3 stated, "Because she has difficulty swallowing."

On 03/05/2020 at 10:44 a.m., an interview was conducted with ASM [administrative staff member] # 3, regional coordinator of nursing services. When asked what standards of practice the nursing staff follow ASM # 3 stated that they follow Perry & Potter and their policies.

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

On 03/03/2020 at 5:20 p.m., ASM # 1, executive director, ASM # 2, director of nursing and ASM # 3, regional coordinator of nursing services, were informed of the above findings.

No further information was provided prior to exit.

References:
[1] A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/aphasia.html

2. Resident # 7 was admitted to the facility with diagnoses that included but were not limited to

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swallowing difficulties, amnesia, and adult failure to thrive.

Resident # 7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/27/2020, coded Resident # 7 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being moderately impaired of cognition for making daily decisions. Resident # 7 was coded as independent and requiring assistance with setup for eating. Section K "Swallowing/Nutritional Status" coded Resident # 7 under K0300 Weight Loss, 2 [two] Yes, not on physician-prescribed weight-loss regimen."

The comprehensive care plan for Resident # 7 with a revision date of 10/08/19 documented in part, "Focus. [Resident # 7] has potential nutritional imbalance and risk for wt [weight] fluctuation r/t [related to] Depression, Hx [history] of CVA [cerebral vascular accident] w/ [with] residual deficit and limited assist with weakness. Revision on 10/09/2018." Under "Interventions", it documented in part, "Provide, serve diet as ordered. Monitor intake and record q [every] meal. Date Initiated: 10/09/2018."

The POS [physician order sheet] for Resident # 7 dated March 2020 documented in part, "02/23/20. Mighty House Shake 3x/day [three times a day] with meals.

The facility's MAR [medication administration record] dated February 2020 for Resident # 7 documented the above physician's order. Further review of the MAR failed to evidence documentation of the administration of "Mighty Shakes on 02/25/20 at 12:00 p.m. and at 5:00

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p.m., on 02/26/2020 at 8:00 a.m., 12:00 p.m. and at 5:00 p.m., and on 02/28/2020 at 8:00 a.m., 12:00 p.m. and at 5:00 p.m.

On 03/04/20 at 4:34 p.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. After reviewing, the physician's order and Resident # 7's MAR dated February 2020 for the missing documentation on the dates and times listed above, ASM # 2 stated that the physician's order should be followed and that Resident # 7 could not have been getting the supplement if it was not documented.

On 03/05/2020 at 10:44 a.m., an interview was conducted with ASM [administrative staff member] # 3, regional coordinator of nursing services. When asked what standards of practice the facility follows, ASM # 3 stated that they follow Perry & Potter and their policies.

Potter and Perry's Fundamentals of Nursing, 6th edition, page 477, reveals the following information: "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients."

On 03/05/2020 at 8:15 a.m., ASM # 1, executive director, and ASM # 3, regional coordinator of nursing services, were informed of the above

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F 684	Continued From page 44 findings.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services for the prevention and treatment of pressure injuries for two of 41 residents in the survey sample, Residents #80 and #93. For Resident #93 the facility staff failed to provide care and services for the treatment of a pressure wound once identified, for 3 days. On 11/19/19, the facility staff identified an unstageable wound on the left heel. The physician and wound care nurse were not notified of the wound and treatment was not initiated until 11/22/19. The facility staff failed to transcribe a physician order for Resident #80's bilateral knee braces accurately to the TAR (treatment administration record), as a result staff failed to ensure Resident #80's bilateral knee braces were	F 686	1. Resident #93 was not negatively affected by not received physician notification and treatment orders for three days to her left heel. The order for the knee brace for resident #80 was clarified and written accurately on the March TAR. 2. Skin sweep conducted by License Nursing staff to identify current residents with potential risk of skin breakdown. 1:1 education provided with Licensed nurse who failed to provide physician notification and treatment order for the wound she documented on the weekly skin sheet. Audit completed for current residents with braces to ensure orders are transcribed accurately on the TAR and physician's orders are followed.	4/14/20

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F 686	Continued From page 45 kept open while the resident was in bed to prevent the development of a pressure injury. The findings include: 1. Resident #93 was admitted on 10/4/19. Diagnoses include but are not limited to peripheral vascular disease, stricture of artery, occlusion and stenosis of right and left carotid arteries, stroke, and atherosclerosis of bilateral legs. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/28/20 coded the resident as being severely impaired in ability to make daily life decisions. Resident #93 was coded as requiring total care for bathing, toileting, and eating; extensive assistance for bed mobility, dressing, and hygiene; and was incontinent of bowel and bladder. A review of the clinical record revealed a weekly skin assessment dated 11/19/19, which included outline figure drawings of the front and back of a human body. On the back drawing, the left heel area was circled and the word "unstageable" was written next to it. LPN #6 signed the assessment (Licensed Practical Nurse). Further review of the clinical record failed to reveal any notes, orders, assessments, wound description, physician, family, or wound nurse notification until 11/22/19. On 3/04/20 at 6:04 PM, in an interview with LPN #6, when asked what was done about the wound	F 686	3. Licensed Nurses educated to ensure physician notification and treatment orders are obtained immediately at the sign of any changes of skin integrity and to follow physician's orders for residents with braces and transcribe them accurately to the TAR. Quality monitoring to be completed daily in morning clinical meeting Monday thru Friday times 4 weeks to ensure areas found on skin sheets have physician's orders, notification and documentation. Quality monitoring to be completed weekly times 4 weeks to ensure residents with orders for braces are being followed according the physician's order. 4.The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	

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once she identified it on 11/19/19, LPN #6 stated, "Treatment was already in progress. There was a treatment order in place for that already." A review of the November 2019 MAR/TAR (Medication Administration Record/Treatment Administration Record) and physician orders was conducted with LPN #6 and revealed there were no previous orders or treatments in place for the heel or evidence of any heel wound prior to 11/19/19. LPN #6 stated that what was documented (the notation of an unstageable heel wound on skin assessment dated 11/19/19) was not her handwriting even though she validated it was her signature on the assessment. LPN #6 stated, "I looked at her skin and I did not see any area on her heel on that day. I did not write that (unstageable)." LPN #6 stated, "When we find an area, we do an SBAR (Situation-Background-Assessment-Recommendation), an incident report, call the doctor, call the family. LPN's are not supposed to stage a wound." When asked what is documented about a wound, she stated, "Document on the wound, that there is a wound or open area, and the site, measurements, if there is any drainage, describe the wound, color."

A skin assessment dated 11/22/19 was reviewed. This assessment was written and signed by RN #6 (Registered Nurse) the wound care nurse. This assessment also documented an unstageable wound identified on the left heel.

Further review of the clinical record revealed an SBAR note dated 11/22/19 by RN #6. This note documented the identification of an unstageable pressure ulcer, physician notification of the wound, and the initiation of treatment of skin prep and foam dressing daily.

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A nurse's note dated 11/22/19 by RN #6 documented, "Resident has an unstageable pressure ulcer to the left heel. I informed residents nurse, floor supervisor, MD (medical doctor), RP (responsible party) and DON (Director of Nursing). SBAR, incident report, care plan, wound sheet and treatment orders have been written. Treatment consists of cleansing wound and skin prep daily. Will continue to monitor."

A Pressure Ulcer Record report was started on 11/22/19 by RN #6, and documented the left heel wound as unstageable with black eschar with measurements of 1.5x1.6x0 (in centimeters).

On 3/05/20 at 11:08 AM, an interview was conducted with RN #6. RN #6 stated that she was in a meeting on 11/22/19 and "we were going over the weekly skin assessments and I was asked if I was notified that the resident had a wound, and I said no, and I went upstairs to check her heel because it was marked on the skin sheet for the 19th. I went upstairs, checked her heel, and saw that she, (Resident #49) did have a pressure ulcer to her heel and I came back and told them she did have a wound on her heel. I was asked how did I not know, and I said that there are no treatments ordered and there was nothing in the 24-hour report saying that there was a change in the skin condition."

On 3/05/20 at 11:08 AM, an interview was conducted with RN #6. She stated that she was in a meeting on 11/22/19 and "we were going

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over the weekly skin assessments and I was asked if I was notified that the resident had a wound, and I said no, and I went upstairs to check her heel because it was marked on the skin sheet for the 19th. I went upstairs, checked her heel, and saw that she did have a pressure ulcer to her heel and I came back and told them she did have a wound on her heel. I was asked how I did not know (about the wound), I said that there were no treatments ordered and there was nothing in the 24-hour report saying that there was a change in the skin condition." RN # 6 stated, "Then we did a skin sweep. I wrote a treatment order for her [Resident #93], which was the skin prep, and to float heels (a review of the orders revealed this order was put in place). After a while of doing the skin prep, the wound was stable but I wanted the wound doctor to look at it. I don't recall when that was. He started seeing her wound and we changed the treatments based on what he said. In the meeting (of 11/22/19) we were discussing the wound sheet. To my knowledge before the wound she was being turned and repositioned at least on my shift (day shift), I don't know about other shifts. She had a specialty mattress and repositioning because she does not move as often."

On 3/05/20 at 11:29 AM, in an interview with CNA #4 (Certified Nursing Assistant), she stated she had been working with Resident # 93 since she was moved to the unit (10/24/19). She stated she normally works with the resident on the evening shift. CNA #4 stated the resident [Resident # 93] cannot reposition herself in bed. CNA #4 stated, "We reposition her." She stated the resident was being repositioned every 2 hours in October and

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November 2019. CNA #4 stated she was floating the heels on pillows. She stated that the resident now has a blue foam floating device for floating her heels that was initiated "maybe 3 months ago." This device was observed when the resident was in bed throughout the survey. CNA #4 stated, "She was in boots before (pressure relieving boots)." CNA #4 stated, "(Resident #93) has been using the heel boots since she came to the unit." When asked about bathing, CNA #4 stated that all bathing - showers, bed baths and partial baths include the feet. CNA #4 stated, "I look at her feet for change of skin condition." CNA #4 stated she did not recall when she first saw a change in condition of the left heel. CAN #4 stated, "It was a small black spot on the heel. I reported it to the nurse. The first time I saw it, it was black." When asked if the resident was compliant with interventions, sCNA #4 stated, "She (Resident #93) is compliant with interventions, does not complain."

A review of the CNA documentation logs for bathing revealed the resident had either bed baths or partial baths each day in the days preceding the 19th. There was no evidence in the clinical record of any CNA's reporting a change in skin condition identified during the baths.

A review of the wound care, physician notes revealed his initial evaluation of the wound was on 1/21/20. This note documented the wound as having an etiology of pressure, staging as unstageable, tissue type of eschar, dressing type as skin prep daily, and wound size of 1.5 cm (centimeters) x 1.7 cm x 0 cm.

Subsequent wound care, physician notes were

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reviewed and the most recent note available, dated 2/25/20, documented the wound as 1.1x0.6x0.1 with 100% granulated tissue.

On 3/05/20 at 11:36 AM with ASM #4 (Administrative Staff Member, the Wound Care Physician), he stated that the wound was "more arterial / vascular than pressure. She has PVD (peripheral vascular disease). Lack of blood flow is her biggest issue."

On 3/05/20 at 12:15 PM, in an interview with LPN #2, when asked about the process staff follows for assessing resident's skin, LPN #2 stated, "We have a weekly assessment for checking the skin. I like to do mine in the morning when the CNA gets the residents ready. We check for redness, bruises, or any open areas, or edema, anything new." When asked about the process staff follows if something new is identified, LPN #2 stated, "Right away let the unit manager know, call the MD (medical doctor), get a new order, let family know, let the wound nurse know." LPN #2 further stated, "Document it in the weekly skin assessment book for the date I find it, on the resident chart in a nurse's note, and an incident report, SBAR, care plan."

A review of the comprehensive care plan revealed one for "(Resident #93) has Peripheral Vascular Disease" and included the interventions, "Monitor the extremities for s/sx (signs and symptoms) of injury, infection or ulcers" and "Monitor/document/report PRN (as-needed) any s/sx of skin problems related to PVD: Redness, Edema, Blistering, Itching, Burning, Bruises, Cuts, other skin lesions."

A review of the facility policy, "Clinical Guideline

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Skin & Wound" documented, "Licensed Nurse to report changes in skin integrity to the physician/practitioner and resident/responsible party and document in the medical record."

On 3/5/20 at approximately 1:30 PM, ASM #1 (Administrative Staff Member, the Executive Director), ASM #2 (Director of Nursing) and ASM #3 (Regional Coordinator of Nursing Services) were made aware of the findings. No further information was provided by the end of the survey.

2. Resident #80 was admitted to the facility on 4/24/19 with a recent readmission on 2/5/2020 with diagnoses that included but were not limited to end stage renal disease requiring hemodialysis (a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine) (1), peripheral vascular disease (any abnormal condition, including atherosclerosis, affecting blood vessels outside the heart) (2), diabetes and bilateral tibia plateau fractures.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 2/12/2020 coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she was independent after set up assistance was provided.

The "Skin Evaluation" dated 2/24/2020 documented the resident had bruises on the bilateral knees.

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The orthopedic consult dated 2/25/2020 documented, "NWB (non weight bearing). 2. Braces knee applied bilat (bilaterally) - skin precautions to prevent skin breakdown - may keep open when in bed."

A nurse's note dated 2/25/2020 at 4:00 p.m. documented in part, "Resident returned from the orthopedic appt (appointment) with new orders of NWB on BLE (bilateral lower extremities), brace knee applied bilaterally - skin precaution to prevent skin breakdown. May keep open when in bed."

The February TAR (treatment administration record) documented, "2/5/2020 - Apply knee immobilizer to bil (bilateral) knees at all times. May remove to assess skin integrity." This was signed off every day in the month of February. The TAR also documented, "2/25/2020 - Braces knee applied bilaterally; Skin precautions to prevent skin breakdown. May keep open when in bed." Next to this was handwritten, "Duplicate Order." A line was documented across the page and nothing was signed off.

The March 2020 TAR documented, "Apply immobilizer to bilateral knees at all times - may remove to assess skin integrity." It was signed off as completed every shift from 3/1/2020 through 3/4/2020. The order dated 2/25/2020 did not appear on the March TAR.

The nurse's notes of 2/26/2020, 2/27/2020 and 2/28/2020 did not document the use of the bilateral braces.

A nurse's note dated 2/29/2020 at 12:30 p.m.

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documented in part, "Braces on." The nurse's note of 2/29/2020 at 6:00 p.m. documented in part, "Braces kept in place."

The nurse's note of 3/1/2020 failed to evidence documentation regarding the braces.

The nurse's note dated, 3/2/2020 at 6:50 a.m. documented in part, "Bilateral knee immobilizer in place."

The SBAR (Situation Background Appearance and Review) form dated 3/2/2020 at 10:50 a.m. documented in part, "Open area to (R) (right) lateral knee."

The "Pressure Injury Record" dated 3/2/2020 documented in part, "Present on Admission - a check mark was documented next to no. Location: (R) lateral knee. Measurements: 0.8 x 0.5 x 0.1 cm (centimeters) The wound bed was documented as being eschar (a scab or crust that forms on the skin after a burn) (3). The wound bed color was documented as yellow.

The comprehensive care plan dated,3/2/2020 documented in part, "Focus: (Resident #80) has a pressure ulcer to the right lateral knee r/t (related to) knee brace being too tight." The "Interventions" documented in part, "Educate resident/family of causative factors and measures to prevent skin injury. Keep skin clean and dry. Use lotion on dry skin. Do not apply on site of injury. Knee brace will be kept open while resident is in bed per request. Knee brace will be fasten to dialysis treatment and transfers."

An interview was conducted with RN (registered nurse) # 6, the wound nurse, on 3/4/2020 at 3:31

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p.m. When asked how she was made aware of the pressure injury on Resident #80's right lateral knee, RN #6 stated the physical therapist was in the room and getting her ready for dialysis. She called me into the room. The wound was observed to be red around the wound bed. The wound bed itself had yellow slough, half was yellow and half was granulated tissue. She stated she had coded it as unstageable. RN #6 stated she had completed the SBAR, updated the care plan, notified the doctor for treatment order and she completed the treatment that day. When asked when she had observed the resident's legs prior to 3/2/2020, RN #6 stated she had seen them on the previous Friday. When asked if she had noticed anything abnormal on Friday, RN #6 stated no. When asked how often is her skin to be checked, RN #6 stated, daily. When asked if there was any documentation of her assessing the skin on Friday, RN #6 stated, "No, I just signed off the TAR. I didn't write a nurse's note."

Observation of the resident's wound was conducted on 3/4/2020 at 4:36 p.m. The resident has just returned from dialysis and the wound nurse was changing her dressing for the day. The wound itself had yellow slough covering the wound, the area around the wound was noted to be red.

An interview was conducted with LPN (licensed practical nurse) #3, the nurse who cared for Resident #80 over the weekend, on 3/4/2020 at 4:52 p.m. When asked what should be done with a resident who has braces on both legs, LPN #3 stated they would normally assess the skin integrity, open the braces and check the skin. When asked if she observed the resident's skin over the past weekend, LPN #3 stated she did

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not assess the skin as the wound nurse looked at it over the weekend. Verified with LPN #3 that she did not look at the resident's skin over Saturday or Sunday, LPN #3 stated that was correct.

An interview was conducted with RN #6 on 3/4/2020 at 4:59 p.m. When asked if she worked the past weekend, RN #6 stated she did not work weekends.

An interview was conducted with RN #7, a nurse that worked with Resident #80 over the weekend before the wound was found. When asked if she opened the braces and observed the skin of Resident #80's legs, RN #7 stated the wound nurse does it over the weekend. RN #7 stated the resident sometimes closes them herself. When asked if she observed the skin this weekend, RN #7 stated she only looked to see if the braces were open. She further stated her problem is that she did not document about the braces being open and the care given but it was given by the wound nurse.

An interview was conducted with administrative staff member (ASM) #1, the executive director, on 3/4/2020 at 6:45 p.m. When asked who the wound care nurse on the weekends was, ASM #1 stated he was the supervisor and does the treatments on the weekend. When asked if he is a wound care nurse, ASM #1 stated he was not, he just does the treatments.

An interview was conducted with RN #5 on 3/5/2020 at 9:48 a.m. When asked if he had looked at Resident #80's skin under her braces over the weekend, RN #5 stated he had taken off the braces and looked at the skin. When asked if he saw anything unusual, RN #5 stated, "No,

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Ma'am." When asked where he documented the skin check under the braces, RN #5 stated he signed if off on the TAR.

The TAR for February and March 2020 was reviewed. There were nurse's signatures for all three shifts over the weekend for the skin checks.

A request was made for a policy on caring for a resident with braces on 3/5/2020 at approximately 10:00 a.m.

On 03/05 at 10:44 a.m., an interview was conducted with ASM # 3, the regional coordinator of nursing services. When asked what standards of practice the nursing staff follow ASM # 3 stated that they follow Perry & Potter and their policies.

On 3/5/2020 at 11:20 a.m. ASM #3, the regional coordinator of nursing services, informed this surveyor that the facility did not have a policy on the care of a resident with orthopedic braces. She did present a copy of a page out of a reference book that documented, "Skin - Step: orthopedic and positioning devices such as cast, neck collars and splints." The Rationale - Applied devices have potential to cause pressure to underlying and adjacent skin and tissue. Documented under the strategies to Prevent Medical and Immobilization Device-Related Pressure Injuries, Orthopedic device - All areas where device comes im contact with patient's skin and tissues. Prevention Strategies - When possible and not contraindicated, inspect under the device." (4)

ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional coordinator of nursing services were made aware

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F 686	Continued From page 57 of the above concern. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447. The wound (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 207. (4) Clinical Nursing Skills & Techniques, 9th edition, Perry and Potter, page 999.	F 686		
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	F 761		4/14/20

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F 761	Continued From page 58 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that facility staff failed to ensure a PPD [purified protein derivative] [1] vial was dated when opened and an expired PPD vial were not available for use in one of one medication storage rooms inspected, second floor medication room. The findings include: On 03/05/20 at 8:36 a.m., an observation of the facility's medication room on the second floor was conducted with RN [registered nurse] # 3. Upon entering the medication room, a small refrigerator was observed under the counter on the left side of the room. Observation of the inside of the refrigerator revealed a small red plastic tray containing two multi-dose vials of PPD that were available for use. When asked if the vials of PPD were opened, RN # 3 stated yes. Observation of the first vial failed to evidence an open date. The second opened vial of PPD documented an open date of 1/28/2020. When asked about the first vial of PPD not having an open date, RN # 3 observed the box containing the vial and the vial itself and confirmed that there was not an open date documented on either the vial or the box. RN # 3 further stated that it should have been dated when it was opened. When asked about the second vial of PPD with an open date of 1/28/2020, RN # 3 stated that it was only good for 28 or 30 days after opening and that, it had	F 761	1. The expired biologicals found in the second floor medication room was discarded on 3/5/2020. 2. The DON/Designee completed sweep of both medication rooms to ensure no expired biologicals are present in the medication rooms. 3. Licensed Nursing staff educated to ensure biologicals are dated when opened and expired biologicals are discarded the date they expire if not before. Quality Monitoring by DON/Designee will be completed weekly to ensure there are no expired biologicals in the medication rooms. 4. The findings will be reported to the quality Improvement committee monthly and the plan will be revised as necessary.	

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expired and immediately removed the vials of PPD from the medication room.

On 03/05/2020 at approximately 9:35 a.m., an interview was conducted with RN # 4. When asked to describe the procedure staff follows when opening a multi-dose vial of PPD, RN # 4 stated, "Date it when you open it and store it in the refrigerator." When asked why it was important to date the multi-dose vial when it was opened, RN # 4 stated, "For expiration purposes." When asked if the medication rooms are inspected for expired medications, RN # 4 stated that were inspected monthly.

On 03/05/2020 at 12:15 p.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked how they make sure expired biological are not stored and available for use in the medication rooms, ASM # 2 stated, "We follow our policy."

The facility's policy "5.3 Storage and Expiration of Medications, Biologicals, Syringes and needles" documented in part, "4. Facility should ensure that medications and biologicals that: (1); have an expired date on the label (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. 5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened."

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F 761	Continued From page 60 On 03/05/2020 at 10:44 a.m., an interview was conducted with ASM [administrative staff member] # 3, regional coordinator of nursing services. When asked what standards of practice the nursing staff follow ASM # 3 stated that they follow Perry & Potter and their policies. On 03/03/2020 at 12:15 p.m., ASM # 1, executive director, ASM # 2, director of nursing and ASM # 3, regional coordinator of nursing services, were informed of the above findings. No further information was provided prior to exit. References: [1]PPD skin test is a method used to diagnose silent (latent) tuberculosis (TB) infection. This information was obtained from the website: https://medlineplus.gov/ency/article/003839.htm.	F 761		
F 804 SS=B	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to serve food at palatable temperatures for meal enjoyment during the	F 804	1. The facility staff is serving food at an appetizing/palatable temperature. 2. The Executive Director or designee will	4/14/20

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F 804	Continued From page 61 lunch meal service on 3/3/2020. The findings include: On 3/3/20 at 11:46 AM, an inspection of the tray line service was conducted of the lunch meal. Temperatures of the lunch meal were obtained at the steam table as follows, by OSM #2 (Other Staff Member, the dietary manager), using a facility thermometer: - Mashed potatoes 169 degrees Fahrenheit (F). - Puree green beans 178 degrees - Puree pork 171 degrees - Rice 203 degrees - Pork loin 189 degrees - Mechanical pork 186 degrees - Green beans 183 degrees On 3/3/20 at 2:15 PM, a test tray was conducted of the lunch meal with OSM #2. The following temperatures were obtained by OSM #2 using a facility thermometer: - Mashed potatoes 134 degrees Fahrenheit (F). This was a 35-degree drop in temperature. - Puree green beans 137 degrees F. This was a 41-degree drop in temperature. - Puree pork 127 degrees F. This was a 44-degree drop in temperature. - Rice was 128 degrees F. This was a 75-degree drop in temperature. - Pork loin 121 degrees F. This was a 68-degree drop in temperature. - Mechanical pork 125 degrees F. This was a 61-degree drop in temperature. The Green beans temperature was 114 degrees F. This was a 69-degree drop in temperature.	F 804	complete quality review observations during meal delivery to ensure food is served at a palatable and appetizing temperature. Follow up based on findings. 3. The Dietary Manager was educated by the Regional Dietary Manager on preparing and serving food at an appetizing and palatable temerature. The Executive Director or Designee will complete quality review weekly for 8 weeks of the food temperatures and palatability of food served. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	

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F 804	Continued From page 62 On 3/3/20 at 2:15 PM, the above food items were taste tested with 2 surveyors and OSM #2. All agreed that the pureed items and mashed potatoes were ok, but none of the other items were at temperatures palatable for meal enjoyment. On 3/03/20 at 4:01 PM, an interview was conducted with OSM #2. When asked about meal temperatures, OSM #2 stated, "I understand. People don't want a lukewarm meal." On 3/04/20 at 10:30 AM, a group interview was conducted of five current facility residents. The resident consensus was that food is cold when served in their room. A review of the facility policy, "Meal Distribution" documented, "Meals are transported to the dining locations in a manner that ensures proper temperature maintenance...." On 3/4/20 at 6:40 PM, ASM #1 (Administrative Staff Member, the Executive Director), ASM #2 (Director of Nursing) and ASM #3 (Regional Coordinator of Nursing Services) were made aware of the findings. No further information was provided by the end of the survey.	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		4/14/20

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F 812	Continued From page 63 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to serve food in a sanitary manner. During the lunch meal on 3/3/2020, OSM (other staff member) #4, a dietary aide, was observed plating food for resident trays. OSM #4 touched multiple items while wearing gloves and then wearing the same gloves touched the food contact, surface area of plates, and grabbed dinner rolls with his hand, placing one on each plate, wearing the same gloves. The findings include: On 3/3/20 at 11:46 AM, an inspection of the tray line service was conducted of the lunch meal. The preparation of the meal trays began at 12:27 PM. The following was observed: OSM #4 (Other Staff Member, dietary aide) was at the steam table, plating the food for each tray. He had gloves on, however; he was noted to be touching multiple items in his vicinity including serving spoon handles, the surface of the steam	F 812	1. The facility staff is preparing and serving food in a sanitary manner. OSM #4 had 1:1 education in serving food in a sanitary manner. 2. The Executive Director will complete a quality review observations during meal delivery to ensure the food is prepared and served in a sanitary manner. Follow up based on findings. 3. The Dietary Manager was educated by Regional Director of Operations on preparing and serving food in a sanitary manner on 3/9/2020. The Dietary staff was educated on serving food in a sanitary manner. The Executive Director or designee will complete quality reviews of the kitchen and dining rooms weekly for 8 weeks to validate that food are being prepared and served in a sanitary manner. 4. The findings will be reported to the	

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F 812	Continued From page 64 table, and the handles of a wheeled cart on which plates were stacked at his left side, contaminating his gloves. As he obtained each plate from the cart, he had his thumb on the food contact, surface area, of the rim of the plate. In addition, after plating the food items from the steam table, he reached to another cart at his right side, which contained a tray of dinner rolls. He grabbed each dinner roll with his hand and placed one on each plate, wearing the same contaminated gloves. On 3/03/20 at 4:01 PM, an interview was conducted with OSM #2, the dietary manager. When asked about the observations of thumbs on the plates and handling of the dinner rolls, OSM #2 stated, "Staff should not have their thumbs on the plates and should be using tongs for the rolls. A review of the facility policy, "Meal Distribution" documented, "Proper food handling techniques to prevent contamination and temperature maintenance controls will be used for point-of-service dining." On 3/4/20 at 6:40 PM, ASM #1 (Administrative Staff Member, the Executive Director), ASM #2 (Director of Nursing) and ASM #3 (Regional Coordinator of Nursing Services) were made aware of the findings. No further information was provided by the end of the survey.	F 812	quality improvement committee monthly and the plan will be revised as necessary.	
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	F 842		4/14/20

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F 842	Continued From page 65	F 842		

resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted 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.

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F 842	Continued From page 66 §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 clinical record review and staff interview it was determined that the facility failed to ensure a complete and accurate medical record for one of 41 residents in the survey sample, Resident # 7. The facility staff failed to document the percentage of food eaten by Resident #7 at meals. The findings include: Resident # 7 was admitted to the facility with diagnoses that included but were not limited to swallowing difficulties, amnesia, and adult failure to thrive. Resident # 7's most recent MDS (minimum data	F 842	1. The meal percentage is being documented for each meal for Resident # 7. 2. Audit completed for current resident meal intake percentages to ensure they are documented for each meal. 3. CNA's were educated by the Director of Nursing/Designee to ensure meal percentages are documented in POC for each meal. Quality Monitoring to be completed 5 times a week for 4 weeks to ensure meal percentages are documented in POC by CNA's. Follow up based on findings.	

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F 842	Continued From page 67 set), a quarterly assessment with an ARD (assessment reference date) of 02/27/2020, coded Resident # 7 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being moderately impaired of cognition for making daily decisions. Resident # 7 was coded as independent and requiring assistance with setup for eating. Section K "Swallowing/Nutritional Status" coded Resident # 7 under K0300 Weight Loss, 2 [two] Yes, not on physician-prescribed weight-loss regimen." The comprehensive care plan for Resident # 7 with a revision date of 10/08/19 documented in part, "Focus. [Resident # 7] has potential nutritional imbalance and risk for wt [weight] fluctuation r/t [related to] Depression, Hx [history] of CVA [cerebral vascular accident] w/ [with] residual deficit and limited assist with weakness. Revision on 10/09/2018." Under "Interventions", it documented in part, "Provide, serve diet as ordered. Monitor intake and record q [every] meal. Date Initiated: 10/09/2018." The facility's ADL [activities of daily living] record for Resident # 7 dated February 2020 documented, "ADL - Eating Meal Percentage. 0900 [9:00 a.m.] Day, 1300 [1:00 p.m.] Day, 1800 [6:00 p.m.] Evening." Further review of the ADL record failed to evidence documentation of meal percentages at 9:00 a.m. on: 02/01/2020, 02/03/2020 through 02/11/2020, 02/14/2020, 02/16/2020 through 02/23/2020, 02/25/2020 through 02/29/2020; Further review of the ADL record failed to evidence documentation of meal percentages at 1:00 p.m. on:	F 842	4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary	

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F 842	Continued From page 68 02/01/2020, 02/03/2020 through 02/12/2020, 02/14/2020, 02/16/2020 through 02/23/2020, 02/25/2020 through 02/29/2020. The ADL record failed to evidence documentation of meal percentages at 6:00 p.m. on 02/04/2020, 02/09/2020, 02/18/2020, and 02/23/2020 and on 02/28/2020. The facility's ADL record for Resident # 7 dated March 2020 documented, "ADL - Eating Meal Percentage. 0900 Day, 1300 Day, 1800 Evening." Further review of the ADL record failed to evidence documentation of meal percentages at 9:00 a.m. on 03/02/2020 through 03/04/2020, at 1:00 p.m. on 03/02/2020 through 03/04/2020 and at 6:00 p.m. on 03/03/2020. On 03/04/20 at 4:34 p.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked why it was important to document the amount of food a resident consumes at each meal ASM # 2 stated to be able to track the amount of intake. After reviewing the missing documentation on the ADL record for Resident # 7 dated February and March 2020 for the dates listed above, ASM # 2 stated that they are unable to determine, how much the resident is eating at her meals or any type of trend for weight loss. On 03/05/2020 at 10:44 a.m., an interview was conducted with ASM [administrative staff member] # 3, regional coordinator of nursing services. When asked what standards of practice the nursing staff follow ASM # 3 stated that they follow Perry & Potter and their policies.	F 842		

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F 842	Continued From page 69 Potter and Perry's Fundamentals of Nursing, 6th edition, page 477, reveals the following information: "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients." On 03/04/2020 at 6:40 p.m., ASM # 1, executive director, ASM # 2, director of nursing and ASM # 3, regional coordinator of nursing services, were informed of the above findings. No further information was provided prior to exit.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		4/14/20

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reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

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F 880	Continued From page 71 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to implement infection control practices for one of 41 residents in the survey sample, Residents # 4. During the lunch meal observation on 3/3/2020, CNA (certified nursing assistant) #3 was not observed sanitizing or washing their hands while after assisting a resident with their meal and before they resumed assisting Resident #4 with their meal. The findings include: Resident # 4 was admitted to the facility with diagnoses that included but were not limited to: aphasia [1] and swallowing difficulties. Resident # 4's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/27/2020, coded Resident # 4 as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition for making daily decisions. Resident # 4 was coded as requiring extensive assistance of one staff member for eating. Section K "Swallowing/Nutritional Status" coded Resident #	F 880	1. Infection control practices are being followed during meals. 2. CNA #3 was provided 1:1 education by the Director of Nursing for infection control practices during resident meal time. 3. Nursing staff education by Director of Nursing/ Designee on infection control practices when feeding residents at meals. Quality Monitoring to be completed 3 times a week for 4 weeks to ensure infection control is being followed during meal times. Follow up based on findings. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	

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F 880	Continued From page 72	F 880		

4 as having a "Mechanically altered diet - require change in texture of food or liquids (e.g., pureed foods, thickened liquids)."

On 03/03/2020 at 1:10 p.m., an observation of the lunch meal was conducted on the facility's first floor dayroom. Observations of Resident # 4 revealed the resident was sitting in a wheelchair at the table with CNA [certified nursing assistant] # 3 was seated next to them. Observation of Resident # 4's lunch tray revealed that it contained pureed consistency food, thickened coffee and a cup of thin juice. Observation of CNA # 3 revealed they were feeding Resident # 4 their food and providing sips of liquids. Further observation of CNA # 3, revealed that during the course of the meal, CNA # 3 turned to another resident on their right side, picked up the resident's cup of juice with their right hand, and assisted the resident in taking a sip. CNA #3 then turned back to Resident # 4, picked up Resident # 4's cup with their right hand, and assisted Resident # 4 in taking a sip. CNA # 3 not observed washing their hands or using sanitizer on their hands between assisting each resident.

On 03/03/20 at 2:37 p.m., an interview was conducted with CNA [certified nursing assistant] # 3. When asked about washing or sanitizing their hands when serving Resident # 4, after assisting another resident, CNA # 3 stated that they should have sanitized their hands after assisting the other resident

On 03/05/2020 at 10:44 a.m., an interview was conducted with ASM [administrative staff member] # 3, regional coordinator of nursing services. When asked what standards of practice the facility follows, ASM # 3 stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495361	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WOODBRIDGE, LLC	14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 73 they follow Perry & Potter and their policies. On 03/03/2020 at 5:20 p.m., ASM # 1, executive director, ASM # 2, director of nursing and ASM # 3, regional coordinator of nursing services, were informed of the above findings. No further information was provided prior to exit. References: [1] A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html	F 880		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to ensure the kitchen area was free of pests. Two flies were observed flying in the area where dishes were stored on racks for air-drying, and a fly was observed flying around the area of the steam table where the lunch meal foods was already set up but were covered. The findings include: On 3/3/20 at 10:15 AM, an initial kitchen	F 925	1. Steritech came out and treated for drain flies in the kitchen on 3/17/2020. 2. The Dietary Manager and Maintenance Director educated by Executive Director to call Steritech when drain flies are seen in the kitchen area. 3. Dietary Staff educated by Executive Director on presence of drain flies and to report presence of drain flies to the Maintenance Director immediately so that	4/14/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 925	Continued From page 74 inspection was conducted. Two flies were observed flying in the area where dishes were stored on racks for air-drying, located between the dishwashing area and a storage area across the aisle from the dishwashing area. On 3/3/20 at 12:24 PM, an inspection of the tray line service was conducted of the lunch meal. A fly was observed flying around the area of the steam table where the lunch meal foods was already set up but were covered. A review of the pest control company visits for December 2019, January 2020, and February 2020 revealed a visit dated 2/18/20 which documented, "Targeted Pests: Flies, Miscellaneous flies, Other, Fats, Oil, Greases. Area: Kitchen. Equipment used: Aerosol Linear Feet. Comments: Treated the drains." On 3/03/20 at 4:01 PM, an interview was conducted with OSM (other staff member) #2, the dietary manager. When asked about the flies, OSM #2 stated, "We have pest control come out and treat the brand new filter system. We have to keep the drain in the floor by the juice station clean and dry at all times, if not it causes the flies to come. A review of the "Pest Control" policy documented, "A program will be established for the control of insects and rodents for the Dining Services department. 1. The Dining Services Director coordinates with the Director of Maintenance to arrange pest control services on a monthly basis, or as needed. 2. All food preparation, service and storage areas will be monitored regularly for any signs of pest/vermin. The center staff will be notified immediately of any concerns. 3. Where applicable, bulk foods will be removed from their	F 925	pest control can be contacted to treat kitchen area. Quality monitoring to be completed weekly x 4 weeks by the Dietary Manager or designee to ensure drain flies are not present in the kitchen. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary	

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F 925	Continued From page 75 original packaging and stored in containers with tight fitting lids." A review of the facility policy, "Meal Distribution" did not document anything regarding preventing pests in the kitchen area. On 3/4/20 at 6:40 PM, ASM #1 (Administrative Staff Member, the Executive Director), ASM #2 (Director of Nursing) and ASM #3 (Regional Coordinator of Nursing Services) were made aware of the findings. No further information was provided by the end of the survey.	F 925		