STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ B. WING _____	08/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL WISE	9434 COEBURN MOUNTAIN ROAD WISE, VA 24293

(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 8/14/21 through 8/16/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 08/14/21 through 08/16/21. Corrections were required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 97 certified bed facility was 87 at the time of the survey. The final survey sample consisted of 18 current resident reviews and 3 closed record reviews.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the residents receive treatment and care in accordance with the comprehensive person-centered care plan for 1 of 21 residents in	F 684	**F684** **Corrective Action(s):** Resident #67's attending physician has been notified that the facility failed to follow physician's order for the administration of Norvasc to hold the medication if the systolic BP was below 150 on 13 occasions.	

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

Administrator | 9/2/21

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

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F 684	Continued From page 1 the survey sample, Resident #67. The findings included: For Resident #67, the facility staff failed to follow the physician's order for the administration of Norvasc, a calcium channel blocker used to treat hypertension and coronary artery disease. Resident #67's diagnosis list indicated diagnoses, which included, but not limited to Essential (Primary) Hypertension, Heart Failure Unspecified, Cerebral Infarction Unspecified, Unspecified Dementia without Behavioral Disturbance, Cerebrovascular Disease Unspecified, and Chronic Obstructive Pulmonary Disease Unspecified. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 7/23/21 assigned the resident a BIMS (brief interview for mental status) score of 3 out of 15 in section C, Cognitive Patterns. In section I, Active Diagnoses, Resident #67 was coded for the presence of Heart Failure and Hypertension. Resident #67's current physician's orders included an active order dated 5/12/21 stating "Norvasc 10 mg tablet admin (administer) 10 mg tablet PO (by mouth) Q (every) HS (bedtime) if systolic <150 hold med DX: HTN". A review of Resident #67's August 2021 MAR (medication administration record) on 8/15/21 revealed Norvasc was administered with the resident's systolic blood pressure below 150 on 13 separate occasions: 8/01/21 given with BP (blood pressure) of 128/80 8/02/21 given with BP of 136/80 8/03/21 given with BP of 130/72	F 684	**Identification of Deficient Practices/Corrective Action(s):** All residents with physician's orders for administration of medications may have been potentially affected. The DON and/or designee will conduct a 100% audit of all resident medication records to identify residents at risk of not receiving their medications as ordered by the physician. Providers of residents identified at risk will be notified and will assess those residents. The attending physicians will be notified of each negative finding. **Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician orders, medication orders, treatment orders. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for ensuring residents are assessed by a provider when indicated.	

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F 684	Continued From page 2 8/04/21 given with BP of 140/80 8/05/21 given with BP of 138/80 8/06/21 given with BP of 138/74 8/08/21 given with BP of 135/89 8/09/21 given with BP of 149/83 8/10/21 given with BP of 144/70 8/11/21 given with BP of 142/86 8/12/21 given with BP of 142/86 8/13/21 given with BP of 133/61 8/14/21 given with BP of 132/76 On 8/15/21 at 11:40 am, surveyor notified the DON (director of nursing) of Resident #67 receiving Norvasc with a systolic blood pressure below 150 on 13 occasions thus far during August. Resident #67's current comprehensive person-centered care plan included a problem area stating in part "Cardiovascular/Respiratory: (Resident #67)'s vital signs have been stable. No s/s (signs/symptoms) of JVD (jugular vein distension), Edema or SOB (shortness of breath) have been noted since admission. DX: COPD (chronic obstructive pulmonary disease), CVA (cerebrovascular accident), Type 2 DM (diabetes mellitus), Heart Failure ..." An approach states "medications/labs as ordered. Inform MD of any changes". On 8/15/21 at 4:30 pm during a meeting with the administrator, DON, and regional nurse consultants, surveyor discussed the concern of Resident #67's medication errors for Norvasc administration. No further information regarding this issue was presented to the survey team prior to the exit conference on 8/16/21.	F 684	**Monitoring:** The DON will be responsible for maintaining compliance. The DONand/or Unit Managers will perform weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/30/21**	

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to ensure the resident environment remains as free of accident hazards as is possible for 1 of 21 residents in the survey sample, Resident #7. The findings included: For Resident #7, the facility staff failed to dispose of the resident's excess topical medication in a manner to prevent the resident from gaining access. Resident #7's diagnosis list indicated diagnoses, which included, but not limited to Acute Kidney Failure Unspecified, Chronic Kidney Disease Stage 4 (Severe), Chronic Obstructive Pulmonary Disease Unspecified, Heart Failure Unspecified, Unspecified Osteoarthritis Unspecified Site, Pain in Left Knee, Pain in Right Knee, and Essential Hypertension. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 5/28/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15	F 689	**F689** **Corrective Action(s):** Resident #7's attending physician has been notified that the facility staff failed to dispose of the resident's excess topical medication in a manner to prevent the resident from gaining access to it **Identification of Deficient Practices/Corrective Action(s):** All other residents with topical medications ordered may have been potentially affected. The DON and/or Unit Manager will conduct a 100% review of all residents receiving topical medications to identify residents at risk. All residents identified at risk will be corrected at time of discovery. **Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. The DON and/or regional nurse consultant will inservice all nursing staff regarding proper disposal of excess topical medications. **Monitoring:** The DON is responsible for maintaining compliance. The DON/designee will perform twice weekly observations of topical medication administration. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these reviews will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy . **Completion Date: 9/30/21**	

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F 689	Continued From page 4 in section C, Cognitive Patterns. On 8/14/21 at 2:48 pm during initial rounding in Resident #7's room, surveyor observed five (5) medicine cups each containing a small amount of a white cream substance. The cups were sitting on a nightstand located directly across from the foot of the Resident #7's bed. Surveyor observed Resident #7's roommate walk by the nightstand with the medicine cups; the roommate is independently mobile and must pass by the nightstand in order to exit the room. Resident #7 was not in their room at the time of the observation. At 2:50 pm, LPN (licensed practical nurse) #1 accompanied the surveyor to Resident #7's room and observed the five medicine cups containing the white cream substance. Surveyor asked LPN #1 what the substance was in the cups and LPN #1 stated "that's a good question, I'll get (his/her) nurse". At 2:52 pm, LPN #2 entered Resident #7's room and stated the medicine cups contained "Aspercreme" and Resident #7 gets the medicine cups out of the trash and if there is any left in them (he/she) keeps them. LPN #2 proceeded to collect the five medicine cups and threw them away in Resident #7's trash can. On 8/15/21 at 10:08 am, surveyor met with Resident #7 in their room and asked the resident about the medicine cups containing the white cream substance observed the day prior. Resident #7 stated "that's for my knees". Surveyor asked the resident if staff leave the cups in their room for them to use and Resident #7 stated "yeah" and "it helps my knees". Surveyor spoke with the DON (director of nursing) on 8/15/21 at 11:40 am and notified them	F 689		

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F 689	Continued From page 5 of the surveyor's observation on 8/14/21. Surveyor reviewed Resident #7's clinical record and was unable to locate a physician's order for Aspercreme. However, Resident #7's current physician's orders included an active order dated 10/19/20 stating "Diclofenac Sodium 1% gel apply 2 GM to left foot four times daily" and an active order dated 2/15/21 stating "Diclofenac Sodium 1% gel apply 2 gm to bilateral knees four times daily". On 8/15/21 at 4:30 pm during a meeting with the administrator, DON, and Regional Nurse Consultants, surveyor discussed the concern of the observation of the five medicine cups containing a white cream substance in Resident #7's room. Surveyor spoke with the DON the following day at approximately 11:00 am and the DON stated they did not think Resident #7 had a self-administration of medications assessment and this morning they have went around to the nurses and instructed them to throw away medicine cups outside of the resident's room. No further information regarding this issue was presented to the survey team prior to the exit conference on 8/16/21.	F 689		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;	F 759	**F759** **Corrective Action(s):** The facility's medical director has been notified that the facility staff failed to ensure a medication error rate of less than 5% involving resident #57.	

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F 759	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, the review of documents, and during medication pass observations, it was determined the facility staff failed to ensure a medication error rate of less than 5%. There were two (2) errors in 31 opportunities resulting in a medication error rate of 6.45%. The findings include: Medications errors were observed while completing the Medication Administration Task. There were two (2) errors in 31 opportunities resulting in a medication error rate of 6.45%. On 8/15/21 at 8:52 a.m., Employee #21 (a licensed practical nurse) was observed administering medications to Resident #57. The following medications were ordered but not administered: Calcium 600-Vit D3 800 one tablet by mouth every day and Olopatadine eye drops one drop to each eye every day. On 8/15/21 at 9:59 a.m., Employee #21 was asked about the failure to administer Resident #57's Calcium/Vit D tablet and Olopatadine eye drops. Employee #21 confirmed the Calcium/Vit D tablet had not been administered because it was not available; Employee #21 stated they would have to call the medical provider to obtain an order to hold this medication. Employee #21 also confirmed they did not administer eye drops to Resident #57. Review of Resident #57's medication administration records (MARs) revealed documentation indicating the Calcium/Vit D tablet and the Olopatadine eye drops had been administered on the morning of	F 759	Resident #57's attending physician has been notified that the facility staff did not administer Calcium 600 – Vit D3 800 as ordered on 8/15/21 and did not administer Olopatadine eye drops as ordered. Employee #21 has received one on one education regarding the medication administration policy. **Identification of Deficient Practices & Corrective Actions(s):** All residents may have potentially been affected. A 100% medication pass audit of all licensed nurses within the facility will be conducted to identify those nurses at risk. One-on-one inservice training and appropriate disciplinary action if warranted for nursing staff observed. **Systemic Change(s):** The facility Policy and Procedure for medication administration and has been reviewed and no changes are warranted at this time. All Licensed nursing staff will be inserviced by the DON or ADON on the facility policy and procedure for medication administration. Inservices will include administering medication per physician order and the 5 rights of medication administration.	

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F 759	Continued From page 7 8/15/21; Employee #21 confirmed the documentation of the medications being administered was incorrect and would need to be corrected. The following information is found in a facility policy titled "Administering Medications" (with a revised date of April 2019): "Medications are administered in a safe and timely manner, and as prescribed ... Medications are administered in accordance with prescriber orders, including any required time frame." The aforementioned medication errors resulting in a greater than 5% medication error rate was discussed with the facility's Administrator, Director of Nursing (DON), and two Nurse Consultants, during a survey team meeting, on 8/16/21 at 5:30 p.m.	F 759	**Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON, Unit Manager and/or designee will conduct two random weekly medication pass observations of licensed nurses to monitor for compliance. Any negatives findings will be addressed at the time of discovery and appropriate disciplinary action will be taken. All discrepancies found in these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/30/21**	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761	**F761** **Corrective Action(s):** The open vials of Tuberculin Purified Protein Derivative were discarded during the survey. The unlabeled container of nebulizer medication solution was secured and discarded during the survey.	

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F 761	Continued From page 8 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, clinical record review, and the review of documents, it was determined the facility staff failed to ensure medications were correctly stored on 2 of 2 units and in one (1) resident's room (Resident #7). The findings include: 1. The facility staff failed to ensure open vials of Tuberculin Purified Protein Derivative (PPD) injectable solution was correctly labeled and stored on two (2) of two (2) nursing units. Tuberculin PPD solution is an intradermal injection used to assist with diagnosing tuberculosis (TB). The facility staff provided the survey team with a "Medication Storage Guidance" document which included the following information about the Tuberculin PPD injectable solution: "Date when opened and discard unused portion after 30 days." On 8/16/21 at 10:40 a.m., the facility's medication storage refrigerator, on Unit #2, was observed with Employee #22 (a registered nurse (RN)). One (1) open vial of Tuberculin PPD injectable solution was noted to not be dated; and one (1)	F 761	**Identification of Deficient Practices & Corrective Action(s):** All other unit medication rooms, medication refrigerators used for the storage medications and all medication carts may have been potentially affected. The DON and/or designee will conduct a 100% review of the medication rooms, medication refrigerators, resident rooms, and medication carts to identify any undated, expired or unlabeled medications, equipment or biologicals. Any/all negative findings will be corrected at time of discovery. A Facility Incident and Accident Form will be completed for each incident identified. **Systemic Change(s):** Facility policy and procedure for medication and biological storage have been reviewed and no changes are warranted at this time. All licensed nurses will be inserviced by the DON on the facility policy and procedure for storing medications and biologicals. The nursing staff will also be inserviced on the Medication Administration Policy and Procedure to include weekly inspection of all medication carts, medication rooms and medication refrigerators to remove and discard all undated and expired mediations.	

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F 761	Continued From page 9 open vial of Tuberculin PPD injectable solution was noted to be dated 5/18/21. On 8/16/21 at 10:56 a.m., the facility's medication storage refrigerator, on Unit #1, was observed with Employee #23 (a licensed practical nurse (LPN)). One (1) open vial of Tuberculin PPD injectable solution was noted to not be dated. During an interview on 8/16/21 at 4:00 p.m., Employee #24 (a nurse consultant) reported the aforementioned vials of Tuberculin PPD injectable solution will be discarded. The incorrect storage of the aforementioned vials of Tuberculin PPD injectable solution was discussed with the facility's Administrator, Director of Nursing (DON), and two (2) Nurse Consultants, during a survey team meeting, on 8/16/21 at 5:30 p.m. 2. For Resident #7, the facility staff failed to secure an individual unlabeled container of clear nebulizer medication solution. The nebulizer solution was observed on the resident's over bed table in their room. Resident #7's diagnosis list indicated diagnoses, which included, but not limited to Acute Kidney Failure Unspecified, Chronic Kidney Disease Stage 4 (Severe), Chronic Obstructive Pulmonary Disease Unspecified, Heart Failure Unspecified, Unspecified Osteoarthritis Unspecified Site, Pain in Left Knee, Pain in Right Knee, and Essential Hypertension. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 5/28/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15	F 761	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or unit manager will perform weekly Medication room and medication cart audits to monitor for compliance. All discrepancies found in these audits will be corrected at the time of discovery and disciplinary action taken as appropriate. Results of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/30/21**	

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F 761	Continued From page 10 in section C, Cognitive Patterns. On 8/15/21 at 10:08 am, while speaking to Resident #7 in their room, the surveyor observed an individual unlabeled container of clear nebulizer medication solution standing in a cup on the resident's over bed table. Surveyor asked the resident what the medication was and they stated "that's for my smoking pipe" pointing to a nebulizer located on the nightstand. Resident #7 stated they use it twice a day. At 10:13 am, the UM (unit manager) accompanied the surveyor to the resident's room and observed the container of nebulizer solution. At 10:17 am, the UM stated they "tossed it" and the nurse working now did not leave it in there. UM further stated they would talk to the other nurses about it. Resident #7's current physician's orders included an active order dated 7/25/21 stating "Iprat-Albut 0.5-3(2.5) MG/3 ML via inhalation Q (every) 6 H (hours) PRN (as needed) Dx (diagnosis): COPD (chronic obstructive pulmonary disease) Generic: Ipratropium Bromide/Albuterol Sulfate". A review of Resident #7's July and August 2021 MARs (medication administration record) revealed the medication was last initialed as being administered on 7/24/21. On 8/15/21 at 11:40 am, surveyor notified the DON (director of nursing) of the observation of the individual unlabeled container of clear nebulizer medication solution observed in Resident #7's room. On 8/15/21 at 4:30 pm, surveyor notified the administrator, DON, and Regional Nurse Consultants of the observation of the container of nebulizer medication solution observed in	F 761		

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	495350	A. BUILDING _____ B. WING _____	08/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL WISE	9434 COEBURN MOUNTAIN ROAD WISE, VA 24293

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F 761	Continued From page 11 Resident #7's room. No further information regarding this issue was presented to the survey team prior to the exit conference on 8/16/21.	F 761		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on interviews and the review of documents, it was determined the facility staff failed to provide an ordered therapeutic diet for 1 of 21 sampled resident (Resident #37). The findings include: Facility staff members failed to provide Resident #37 with the medical provider ordered and care planned six (6) small meals a day. Resident #37's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 6/30/21, was signed as completed on 7/1/21. Resident #37 was assessed as rarely or never able to make self understood and as rarely or never able to understand others. Resident #37 was assessed as having short-term and long-term memory problems. Resident #37 was	F 808	**F 808** **Corrective Action(s):** Resident #37's attending physician has been notified that the facility staff failed to provide 6 small meals a day for the resident as ordered and care planned. **Identification of Deficient Practices & Corrective Action(s):** All other residents with therapeutic diet orders may have potentially been affected. The Dietary Manager/designee will conduct a 100% review of all resident diet orders to identify residents at risk. All negative findings will be addressed at the time of discovery and the resident comprehensive plan of care will be updated to accurately reflect the resident's current condition and physician ordered therapeutic diet. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The dietary manager and dietary staff will be inserviced by regional nurse consultant on the policy and procedure regarding providing therapeutic diets as ordered and care planned.	

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F 808	Continued From page 12 assessed as being totally depended on others for bed mobility, transfers, dressing, eating, personal hygiene, and bathing. Resident #37's diagnoses included, but were not limited to: heart disease, Alzheimer's disease, malnutrition, anxiety, and depression. Resident #37 was documented as receiving hospice care. The following information was found in the facility's Dietary Policy and Procedure Manual under the heading of "Accurate Diet Service": "POLICY: Each resident will receive proper nutrition as prescribed by their physician. PROCEDURE: 1. Before each meal service a dietary employee will check the tray cards with a master list to assure the correct diet order is on the card ... 4. The Director of Nursing Services and the Food Service Director with input from the consultant dietitian must review the resident's nutritional problems and coordinate all resolutions. Recommendations must be presented to the attending physician for his or her approval." Employee #26 (the Dietary Manager) reported there was no policy/procedure that specifically addressed providing six (6) small meals a day. Resident #37's provider orders included the following dietary orders: - "Magic cup with meals" dated 4/10/20, and - "Resident is to receive six small meals a day" dated 10/7/20. The following information was found on Resident #37's tray card: "Diet Order: Pureed, Meals 6 Times A Day, Nectar Thick Liquid". Resident #37's nutritional care plan included the following approach: "SIX SMALL MEALS A DAY	F 808	**Monitoring:** The CDM is responsible for maintaining compliance. The CDM will review resident therapeutic diet orders weekly coinciding with the Care plan calendar to monitor for compliance. All negative findings will be corrected at time of discovery. Disciplinary action will be taken for each negative finding noted. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion Date: 9/30/21**	

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F 808	Continued From page 13 AS ORDERED". On 8/16/21 at 1:22 p.m., Employee #26 (the Dietary Manager) was asked about Resident #37's six (6) meals a day order. Employee #26 stated the facility staff provided three regular meals and snacks at 10:00 a.m., 2:00 p.m., and 4:00 p.m. On 8/16/21 at 1:36 p.m., Employee #27 (a Registered Dietitian) was interviewed via telephone. Employee #27 confirmed Resident #37 was provided three (3) regular meals a day with snacks three (3) times a day. Employee #27 reported a menu for six (6) small meals a day had not been created. On 8/16/21 at 1:54 p.m., Resident #37's personal sitter was interviewed; the personal sitter was provided by the resident's family. The personal sitter reported Resident #37 was provided three (3) meals a day and that snacks are available. The personal sitter also stated the family brought snacks for the resident. The failure of the facility staff to provide Resident #37 with the ordered six (6) small meals a day was discussed for a final time with the facility's Administrator, Director of Nursing (DON), and two (2) Nurse Consultants, during a survey team meeting, on 8/16/21 at 5:30 p.m.	F 808		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is	F 842	**F842** **Corrective Action(s):** Resident #57's attending physician has been notified that the clinical record included documentation indicating two medications were administered when they had not been administered.	

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F 842	Continued From page 14 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.	F 842	Resident #77's attending physician has been notified that the clinical record did not include a code status for the resident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. The DON and Unit Manager will conduct a 100% review of all resident medication records to identify residents in the past 60 days who did not have accurate medication administration records. A 100% review of all resident records will be conducted to ensure that the physician's orders contain a code status for the resident. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the DON or regional nurse consultant on clinical documentation standards and maintaining complete and accurate clinical records to include accurate medication administration documentation and resident code status.	

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F 842	Continued From page 15 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interviews and the review of documents, it was determined the facility staff failed to maintain complete and accurate clinical record for two (2) of 21 sampled residents (Resident #77 and Resident #82) and one (1) resident (Resident #57) observed during the Medication Administration Task. The findings include: 1. Resident #57's clinical record included documentation that indicated two (2) medications were administered when they had not been administered. On 8/15/21 at 9:59 a.m., Employee #21 as asked	F 842	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will audit medical records weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/30/21**	

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F 842	Continued From page 16 about the documentation that Resident #57 had been administered a Calcium/Vit D tablet and Olopatadine eye drops on the morning of 8/15/21 when the medications had not been administered. Employee #21 confirmed the Calcium/Vit D tablet had not been administered because it was not available. Employee #21 also confirmed they did not administer eye drops to Resident #57. Review of Resident #57's medication administration records (MARs) included documentation that the Calcium/Vit D tablet and the Olopatadine eye drops had been administered on the morning of 8/15/21; Employee #21 confirmed the documentation of the aforementioned medications being administered was incorrect and would need to be corrected. The following information was found in the facility document titled "DOCUMENTATION NURSING CLINICAL RECORDS" (this document was not dated): "Following the required components for nursing documentation a permanent medical record is maintained for each resident ... Accurate documentation that correspond with the physician's orders." The aforementioned incorrect medication administration documentation was discussed during a meeting, on 8/15/21 at 4:42 p.m., with the facility's Administrator, Director of Nursing (DON), and two (2) Nurse Consultants. 2. Resident #77's provider orders failed to include a code status for the resident. Resident #77's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 7/30/21, was signed as completed on	F 842		

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F 842	Continued From page 17 8/2/21. Resident #77 was assessed as able to make self understood and as usually able to understand others. Resident #77's Brief Interview for Mental Status (BIMS) summary score was a 13 out of 15. Resident #77 was assessed as requiring assistance of two (2) or more individuals with bed mobility, transfers, dressing, and personal hygiene. Resident #77's diagnoses included, but were not limited to: cancer, heart disease, high blood pressure, diabetes, and malnutrition. Review of Resident #77's clinical record failed to reveal a provider order to address the resident's code status. Resident #77's medical provider orders were reviewed with Employee #29 (a registered nurse) on the afternoon of 8/15/21. Employee #29 confirmed Resident #77's clinical record did not include a medical provider order addressing the resident's code status. Employee #29 was asked if the facility's admission orders should have included a code status order; Employee #29 nodded their head in an affirmative manner. Resident #77's clinical record included documentation from a prior medical facility that indicated the resident had been a "full code" at the prior facility. During a telephone interview on 8/15/21 at 4:30 p.m., the facility's Medical Director (MD) was asked about medical provider orders for a resident's code status. The MD reported residents should have an order for either a full code or a DNR. During a meeting, on 8/15/21 at 4:42 p.m. with the facility's Administrator, Director of Nursing	F 842		

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F 842	Continued From page 18 (DON), and two (2) Nurse Consultants, a policy to guide admission orders was discussed. The survey team had been provided a policy that addressed "Admission Criteria" but no policy to detail what should be included in a resident's admission orders. It was discussed that Employee #24 (a nurse consultant) had reported that a policy detailing what should be included in a resident's admission orders was unavailable. No policy detailing what should be included as part of a resident's admission orders was provided to the survey team prior to the conclusion of the survey. The facility policy titled "SELF-DETERMINATION RIGHTS POLICIES" stated in the absence of a valid Do Not Resuscitate (DNR) order that cardiopulmonary resuscitation (CPR) would be initiated if a resident was found in cardiopulmonary arrest. Interviews with facility staff members confirmed that CPR would be provided if there were no DNR order for a resident experiencing cardiopulmonary arrest. The absence of a medical provider code status order for Resident #77 was discussed during a meeting, on 8/16/21 at 5:30 p.m., with the facility's Administrator, Director of Nursing (DON), and two (2) Nurse Consultants. 3. Resident #82's provider orders failed to include a code status for the resident. Resident #82's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 8/5/21, was signed as completed on 8/6/21. Resident #82 was assessed as able to make self understood and as able to understand others. Resident #82's Brief Interview for Mental	F 842		

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F 842	Continued From page 19 Status (BIMS) summary score was a 12 out of 15. Resident #82 was assessed as being dependent on others for bed mobility, transfers, dressing, and personal hygiene. Resident #82's diagnoses included, but were not limited to: anemia, high blood pressure, kidney disease, diabetes, and anxiety. Review of Resident #82's clinical record failed to reveal a provider order to address the resident's code status. Resident #82's medical provider orders were reviewed with Employee #29 (a registered nurse) on the afternoon of 8/15/21. Employee #29 confirmed Resident #82's clinical record did not include a medical provider order addressing the resident's code status. Employee #29 was asked if the facility's admission orders should have included a code status order; Employee #29 nodded their head in an affirmative manner. Resident #82's clinical record included documentation from a prior medical facility that indicated the resident had been a 'DNR (do not resuscitate) but allowed to be intubated' at the prior facility. During a telephone interview on 8/15/21 at 4:30 p.m., the facility's Medical Director (MD) was asked about medical provider orders for a resident's code status. The MD reported residents should have an order for either a full code or a DNR. During a meeting, on 8/15/21 at 4:42 p.m. with the facility's Administrator, Director of Nursing (DON), and two (2) Nurse Consultants, a policy to guide admission orders was discussed. The survey team had been provided a policy that	F 842		

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F 842	Continued From page 20 addressed "Admission Criteria" but no policy to detail what should be included in a resident's admission orders. It was discussed that Employee #24 (a nurse consultant) had reported that a policy detailing what should be included in a resident's admission orders was unavailable. No policy detailing what should be included as part of a resident's admission orders was provided to the survey team prior to the conclusion of the survey. The facility policy titled "SELF-DETERMINATION RIGHTS POLICIES" stated in the absence of a valid Do Not Resuscitate (DNR) order that cardiopulmonary resuscitation (CPR) would be initiated if a resident was found in cardiopulmonary arrest. Interviews with facility staff members confirmed that CPR would be provided if there were no DNR order for a resident experiencing cardiopulmonary arrest. The absence of a medical provider code status order for Resident #82 was discussed during a meeting, on 8/16/21 at 5:30 p.m., with the facility's Administrator, Director of Nursing (DON), and two (2) Nurse Consultants.	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the	F 849	**F849** **Corrective Action(s):** Resident #71's attending physicians have been notified that the facility failed to ensure and coordinate with the Hospice organization. Hospice's plan of care and hospice staff notes were not in the clinical record.	

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F 849	Continued From page 21 resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition.	F 849	**Identification of Deficient Practice(s) & Corrective Action(s):** All other residents with Hospice Services may have potentially been affected. A 100% audit of residents receiving Hospice Services will be completed by DON and/or designee to identify residents at risk. All negative findings will be corrected at the time of discovery. **Systemic Changes:** The facility policy and procedure has been reviewed and no changes are warranted at this time. All Licensed staff will be inserviced by the Administrator/DON and Hospice Representative on the policy and procedure for coordinating care and services with the Hospice Agency for all residents receiving Hospice Services. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Managers will review all physician Hospice orders to ensure that the facility has a coordinated Hospice Care Plan for all residents receiving Hospice Services. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/30/21**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 22 (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice	F 849		

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	495350	A. BUILDING _____ B. WING _____	08/16/2021

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F 849	Continued From page 23 administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice:	F 849		

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F 849	Continued From page 24 (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on interviews and the review of documents, it was determined the facility staff failed to inclued intergrating the hospice plan of care services and clinical documentation into the facility's clinical documentation for 1 of 21 sampled patients (Resident #37). The findings include:	F 849		

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F 849	Continued From page 25 Resident #37's clinical documentation, maintained at the facility, failed to include the hospice's plan of care and hospice staff visit notes. Resident #37's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 6/30/21, was signed as completed on 7/1/21. Resident #37 was assessed as rarely or never able to make self understood and as rarely or never able to understand others. Resident #37 was assessed as having short-term and long-term memory problems. Resident #37 was assessed as being totally depended on others for bed mobility, transfers, dressing, eating, personal hygiene, and bathing. Resident #37's diagnoses included, but were not limited to: heart disease, Alzheimer's disease, malnutrition, anxiety, and depression. Resident #37 was documented as receiving hospice care. Resident #37's provider orders included an order for hospice care dated 6/1/21. Review of Resident #37's clinical documentation maintained by facility staff failed to include copies of hospice staff visit notes and failed to include a copy of the hospice care plan for Resident #37. The following information was found in a facility policy titled "Hospice Program" (with a revised date of July 2017): "Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental and psychosocial well-being."	F 849		

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F 849	Continued From page 26 During an interview on 8/16/21 at 2:50 p.m., the facility's Director of Nursing (DON) reported the hospice documentation was not in the resident's clinical record; the DON reported the hospice documentation had been faxed to the facility on 8/15/21. On 8/16/21 at 3:06 p.m., a copy of the hospice care plan for Resident #37 was requested from the facility's DON. On 8/16/21 at 3:43 p.m., Employee #28 (a licensed practical nurse (LPN)) provided a copy of the hospice care plan to the survey team. Employee #28 reported the care plan had to be faxed from the hospice. The faxed machine had dated the hospice care plan as being faxed on 8/16/21 at 3:30 p.m. The facility's written agreement with the hospice providing care to Resident #37 included the following information: - "HOSPICE'S RESPONSIBILITIES ... Hospice shall furnish to Facility a copy of its recommended Plan of Care for each Hospice Patient." - "RECORDS ... Facility and Hospice shall each prepare and maintain accurate and complete clinical records concerning each Hospice Patient in accordance with prudent record keeping procedures and as required by law. Facility and Hospice shall each retain such records for such time periods as required by applicable law. Facility and Hospice shall coordinate record keeping." The failure of the facility staff to ensure Resident #37's hospice care plan and hospice notes were maintained as part of the resident's clinical documentation at the facility was discussed with	F 849		

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F 849	Continued From page 27 the facility's Administrator, Director of Nursing (DON), and two (2) Nurse Consultants, during a survey team meeting, on 8/16/21 at 5:30 p.m.	F 849		
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, 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	F 880	**F880** **Corrective Action(s):** Resident #44's attending physician has been notified that facility staff failed to implement infection control practices to prevent the spread of infection when a staff member (RN #1) failed to sanitize her hands during the medication administration observation on 8/14/21. Employee #25 has received one on one education regarding handwashing during medication administration. **Identification of Deficient Practice(s) and Corrective Action(s):** All residents may have the potential to be affected by improper infection control practices related to handwashing. The infection preventionist will complete a review of all nursing staff for handwashing. The DON will complete a treatment observation of all nurses who regularly complete medication administration to ensure compliance with handwashing. Any negative findings will be addressed immediately, and disciplinary action taken as needed. **Systemic Change(s):** The facility Infection Control policy and medication administration policy and procedure have been reviewed and no changes are warranted at this time. The infection preventionist has inserviced all staff on handwashing.	

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F 880	Continued From page 28 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 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 observations, interviews, and the review of documents, it was determined the facility staff failed to follow handwashing procedures during Medication Administration Task observations.	F 880	**Monitoring:** The infection preventionist is responsible for maintaining compliance. The infection preventionist will complete QA audits no less than 3 times weekly monitor for compliance. Any negative findings will be corrected at the time of discovery and disciplinary action taken as needed. Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure. **Compliance Date: 9/30/21**	

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F 880	Continued From page 29 The findings include: A facility staff member (Employee #25) (a licensed practical nurse (LPN)) failed to perform hand hygiene when changing gloves during the process of checking Resident #9's blood sugar and subsequently administering an insulin injection to the resident. On 8/14/21 at 4:50 p.m., Employee #25 was observed to check Resident #9's blood sugar and to provide Resident #9 an insulin injection. Employee #25 was observed to wash their hands at the beginning of the episode of care and at the conclusion of the episode of care. Employee #25 was observed to change their gloves, without performing hand hygiene, three (3) times during the process of checking the resident's blood sugar and the administration of insulin. Employee #25 changed their gloves without performing hand hygiene at the following steps of the process: (a) after cleaning the glucometer, (b) after performing the finger stick blood sugar (FSBS) test and prior to cleaning the glucometer, and (c) after cleaning the glucometer and prior to administering the insulin. The following information was found in a facility document titled "Handwashing/Hand Hygiene" (with a revised date of August 2019): - "This facility considers hand hygiene the primary means to prevent the spread of infections." - "Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations ... Before preparing or handling medications ... After handling used dressing, contaminated equipment ... After removing gloves ..."	F 880		

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F 880	Continued From page 30 The failure of a facility staff member to perform hand hygiene when changing gloves was discussed during a survey team meeting, with the facility's Administrator, Director of Nursing (DON), and two Nurse Consultants, on 8/16/21 at 5:30 p.m.	F 880		