

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

PRINTED: 04/20/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/02/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
(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 4/30/19 through 5/2/19. 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 was conducted 4/30/19 through 5/2/19. Complaints were investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow.	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 promote the rights of the resident.	F 550		5/23/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/23/2019

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

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F 550	<p>Continued From page 1</p> <p>§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.</p> <p>§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.</p> <p>§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.</p> <p>§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 serve food in a manner to promote resident dignity for two of 56 residents in the survey sample, Residents # 118 and # 30.</p> <p>1. On 04/30/19 at 12:00 p.m., during lunch service in the facility's main dining room the facility staff failed serve Resident # 118 her meal until after the two other residents seated at the table were served and were eating their meals. Resident # 118 waited fifteen minutes to be</p>	F 550	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance.</p> <p>All alleged deficiencies cited have been or will be corrected by the date or dates</p>		

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F 550	<p>Continued From page 2 served her meal.</p> <p>2. On 4/30/19 during the lunch service in the Arcadia dining room the facility staff failed to serve Resident #30 her meal until after the residents seated at her table had been served and were eating their meals, Resident #30 waited 12 minutes for her meal to be served.</p> <p>The findings include:</p> <p>1. On 04/30/19 at 12:00 p.m., during lunch service in the facility's main dining room the facility staff failed serve Resident # 118 her meal until after the two other residents seated at the table were served and were eating their meals. Resident # 118 waited fifteen minutes to be served her meal.</p> <p>Resident # 118 was admitted to the facility on 12/07/2017 with diagnoses that included but were not limited to: cerebral infarction (1), peripheral vascular disease (2), and anemia (3).</p> <p>Resident # 118's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/05/19, coded Resident # 118 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 # 118 was coded as requiring extensive assistance of one staff member for all activities of daily living and as requiring supervision with set up for eating.</p> <p>On 04/30/19 at 12:00 p.m., an observation was conducted in the facility's main dining room during lunch. Resident # 118 was seated at a table with two other residents. The other residents at the</p>	F 550	<p>indicated.</p> <p>F-550 It is the intended practice of this facility to protect and promote rights of residents.</p> <p>1. Resident #118 and Resident #30 on May 2, 2019 were served food at the same time at the same table to promote resident dignity.</p> <p>2. Residents that were served food in the dining room have the potential to be affected.</p> <p>3. Staff that serve in the dining room were re-educated on the importance of serving food to the residents at the same time at the same table to promote dignity.</p> <p>4. Dietary and/or designee will audit five days a week x 4 weeks and then monthly x 2. This audit will be done through dining observation of making sure that all residents at the same table are served at the same time. Results of the QAA audits will be reviewed by the facility's QAA committee. Recommendations will be discussed and implemented as needed.</p> <p>5. Facility alleged date of compliance is June 11, 2019.</p>		

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F 550	<p>Continued From page 3</p> <p>table were served their meals at approximately 12:20 p.m. Further observation revealed Resident # 118 was not served her meal until 12:35 p.m. and was observed sitting at the table while the other two residents at the same table were eating their lunch.</p> <p>On 05/01/19 at 9:52 a.m., an interview was conducted with OSM (other staff member) # 9, the cook. When asked to describe the procedure staff follows for serving residents seated at the same table their meals, OSM # 9 stated, "Everyone at the table is served at the same time. It's not fair to have someone sit at the table and watch others at the table eat. I would be upset about it." After being informed of the observation of Resident # 118 waiting for her meal while the other residents seat with her at the same table were eating, OSM # 9 stated, "That shouldn't have happened." When asked if she remembered the situation OSM # 9 stated, "I don't recall that."</p> <p>On 05/01/19 at approximately 11:30 a.m., an interview was conducted with Resident 118. When asked how she felt during lunch in the facility's main dining room when the two residents sitting with her were served their meals while she waited for an additional ten to fifteen minutes for her meal, Resident # 118 stated, "Not to good, I was still left to be served, when was she going to give me something to eat. I had to get the girl's attention by waving my hand and I told her she forgot one."</p> <p>On 05/01/19 at 2:54 p.m., an interview was conducted with OSM # 7, dietary manager. When asked to describe the procedure for serving residents a meal seat at the same table,</p>	F 550			

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F 550	<p>Continued From page 4</p> <p>OSM # 7 stated, "You serve everyone at the same table at the same time."</p> <p>The facility's policy "Virginia Patient/Resident Bill of Rights &amp; Responsibilities" documented, "10. Be treated with consideration, respect, and full recognition of your dignity and individuality, including privacy in treatment and in care for your personal needs."</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (administrative staff member) # 1, the interim administrator and ASM # 2, mobile administrator, ASM # 3, executive director of the assisted living facility, and ASM # 4, director of nursing were made aware of the findings.</p> <p>No further information was provided prior to exit.</p> <p>References:</p> <p>(1) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/vasculardisases.html">https://www.nlm.nih.gov/medlineplus/vasculardisases.html</a>.</p> <p>(2) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website:</p>	F 550			

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F 550	<p>Continued From page 5 <a href="https://medlineplus.gov/ency/article/000726.htm">https://medlineplus.gov/ency/article/000726.htm</a> .</p> <p>(3) Low iron. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/anemia.html">https://www.nlm.nih.gov/medlineplus/anemia.html</a></p> <p>2. On 4/30/19 during the lunch service in the Arcadia dining room the facility staff failed to serve Resident #30 her meal until after the residents seated at her table had been served and were eating their meals. Resident #30 waited 12 minutes for her meal to be served.</p> <p>Resident #30 was admitted to the facility on 10/13/14 with the diagnoses of but not limited to Alzheimer's disease. The most recent MDS (Minimum Data Set), an annual Medicare assessment, with an ARD (Assessment reference date) of 2/8/19, documented that Resident #30 was noted to have no speech, was rarely or never able to make herself understood, and was rarely or never able to understand others, indicating the Resident has severe cognitive impairment for daily decision making. The resident was coded requiring extensive assistance for dressing and eating.</p> <p>On 4/30/19 between 12:50 p.m. and 1:20 p.m., an observation was conducted of the Arcadia dining room during lunch. Resident #30 was seated at a table with two other residents. The two other residents received their food at 1:03 p.m. and 1:05 p.m. Resident #30 received her food at 1:17 p.m. after her table mates had received and were eating their food.</p> <p>On 5/2/19 at 1:45 p.m., an interview with CNA (Certified nurse assistant) #3 was conducted.</p>	F 550			

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F 550	Continued From page 6 When asked about the process staff follows for serving residents in the dining room, CNA #3 stated, "When the carts come up, we serve the residents by tables. Everyone at the table is served at the same time. Then we go to another table and serve their food. We serve the residents who can feed themselves first. Ideally, you want the residents who feed themselves to sit at a table together. But they can get up and move around to other tables." When asked about Resident #30's dining experience of having to wait to receiver her food, CNA #3 stated, "Oh, the ones (CNA's) who were assigned to her that day are not regular workers here. They may not have known the protocol." When asked if Resident #30 having to wait for her food is a problem, CNA #3 stated, "Yes. The waiting for food is a problem. It should not have happened"  A review of the facility's policy "Respect, Dignity, Right to have Personal Property" no effective date noted, documented in part, "...Respect and Dignity. The resident has a right to be treated with respect and dignity ..." On 5/2/19 at 4:02 p.m., ASM (Administrative Staff Member) #1 (Interim Administrator), ASM #2 (Mobile Administrator), ASM #4 (Director of Nursing), and ASM #3 (Education Department) were made aware of the findings. No further information was provided by the end of the survey.	F 550			
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) 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,	F 580		5/23/19	

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F 580	<p>Continued From page 7</p> <p>consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(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);</p> <p>(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</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(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.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in</p>	F 580			



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F 580	<p>Continued From page 8</p> <p>§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:</p> <p>Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined the facility staff failed to notify the physician and/or responsible party of a change in condition for four of 56 residents in the survey sample, Residents #93, #12, #26 and #17.</p> <ol style="list-style-type: none"> <li>1. The facility staff failed to notify the physician and/or responsible party when Resident #93's insulin was not administered as ordered.</li> <li>2. The facility staff failed to notify the physician when Resident # 12's insulin (1) was administered with blood sugars (1) below 100 (mg/dl [milligram/deciliter]).</li> <li>3. The facility staff failed to notify the physician when Resident # 12's insulin was administered with blood sugars below 150.</li> <li>4. The facility staff failed to ensure the physician was notified Resident #17's diabetic medications were held without an order, or not administered per the physicians orders.</li> </ol> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The facility staff failed to notify the physician and/or responsible party when Resident #93's insulin was not administered as ordered.</li> </ol>	F 580	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p style="text-align: center;">F-580</p> <p>It is the intended practice of this facility to notify the Physician and/or responsible party of a change in condition.</p> <ol style="list-style-type: none"> <li>1. Upon notification from the surveyor on May 2, 2019, Physician's were notified of change in blood sugar monitoring and insulin administration of residents #93, #12, #26 and #17.</li> <li>2. Residents who receive insulin have the potential to be affected.</li> <li>3. Licensed nurses will be re-educated on the facility guidelines on blood sugar monitoring,</li> </ol>		

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F 580	Continued From page 9  Resident #93 was admitted to the facility on 8/18/17 with a recent readmission on 3/27/18, with diagnoses that included but were not limited to: dementia, psychosis [major mental disorder in which the person is usually detached from reality and has impaired perceptions, thinking, responses and interpersonal relationships (1)], diabetes and high blood pressure.  The most recent MDS (minimum data set) assessment with an assessment reference date of 4/3/19, coded the resident as scoring a "1" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance for most of his activities of daily living. In Section N - Medications, the resident was coded as receiving five days of insulin injections during the look back period.  The physician order dated, 3/27/19, documented, "Insulin Glargine Solution (Lantus) inject 10 unit subcutaneously at bedtime for dm (diabetes mellitus)."  The April 2019 MAR (medication administration record) documented the above physician order. On the following dates, the MAR documented the medication as not administered as ordered: 4/5/19 - a "6" was documented. (The code on the MAR for a "6" was "no insulin per order.") - The resident's blood sugar was documented as "97." 4/6/19 - a "6" was documented. The resident's blood sugar was documented as "96." 4/7/19 - a "6" was documented. The resident's blood sugar was documented as "98." 4/14/19 - a "9" was documented. (The code on	F 580	insulin administration and physician notification of change in conditions.  4. Director of Nursing and/or designee will audit MARs daily x 5 days, then three days a week x 3 weeks and then monthly x 2 months. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed.  5. The facility's alleged date of compliance will be June 11, 2019.		

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F 580	<p>Continued From page 10</p> <p>the MAR for a "9" was "see progress note"). The resident's blood sugar was not documented.</p> <p>4/16/19 - a "9" was documented. The resident's blood sugar was not documented.</p> <p>4/18/19 - a "6" was documented. The resident's blood sugar was documented as "106."</p> <p>4/22/19 - a "6" was documented. The resident's blood sugar was documented as "68."</p> <p>4/23/19 - a "6" was documented. The resident's blood sugar was documented as "114."</p> <p>4/24/19 - a "6" was documented. The resident's blood sugar was documented as "98."</p> <p>Review of the nurse's notes for the month of April failed to evidence any documentation of the reason the insulin was not administered as ordered, notification the doctor or responsible party except on 4/16/19 at 11:58 p.m. the nurse documented, "BS (blood sugar) - 88 Held insulin tonight."</p> <p>The comprehensive care plan dated, 8/18/17, documented in part, "Focus: Insulin therapy to treat DM2 (diabetes mellitus type two). At risk for adverse effects." The "Interventions" documented, "Educate/review current medication, reason for use &amp; (and) administration needs with patient &amp;/or family. Report signs &amp; symptoms of adverse reactions."</p> <p>An interview was conducted with LPN (licensed practical nurse) # 4 on 5/2/19 at 9:25 a.m. LPN #4 (one of the nurse's that held the above ordered insulin). When asked what is Lantus, LPN #4 stated, "Insulin, long acting." When asked a nurse should ever hold Lantus, LPN #4 stated, "If there are parameters for it depends on what the order says." When asked if there are no parameters included in the physicians order, can</p>	F 580			

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F 580	<p>Continued From page 11</p> <p>you hold insulin, LPN #4 stated, "If there is a question, you can call the doctor and get an order." LPN #4 was asked to review the physician order for Resident 93's insulin and the April 2019 MAR. When asked why she didn't give the insulin on the dates above, LPN #4 stated, "It looks like it (the blood sugar) was under 100 and usually we have orders to hold for less than 100." When asked if she had an order to hold the insulin for Resident #93 if the blood sugar was less than 100, LPN #4 stated, "No, Ma'am." When asked what staff should do when they hold a medication, LPN # 4 stated, "We usually contact the doctor and the responsible party." LPN #4 was asked to review her nurse's notes for the above dates. When asked if she had documentation that she contacted the doctor and responsible party when she held the insulin, LPN #4 stated, "It's not there. I didn't do it."</p> <p>An interview was conducted with LPN #5 on 5/2/19 at 10:01 a.m. LPN #5 (one of the nurse's that held the above ordered insulin). When asked what is Lantus, LPN #5 stated, "Insulin." When asked if it's long acting or short acting, LPN #5 stated, "I believe it's long acting." When asked if a nurse should hold Lantus insulin, LPN #5 stated, "If there are specific parameters on the orders we are supposed to." LPN #5 reviewed the physician orders for Resident #93's insulin, the April 2019 MAR and nurse's notes. When asked if the physician ordered specific parameters for this resident's insulin, LPN #5 stated, "No." LPN #5 verified her initials on the MAR. When asked why the insulin was held, LPN #5 stated, "Because the blood sugar was low. I shouldn't have done that. I should have called the doctor. That is my error." When asked if she called the doctor, LPN #5 stated, "No."</p>	F 580			

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F 580	Continued From page 12  The facility policy, "Notify of Changes (Injury/Decline/Room, Etc.)" documented in part, "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's representative(s) when there is...(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)."  In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient.  Fundamentals of Nursing Lippincott Williams and Wilkins 2007 page 185 " ...make sure you record ...any omission or withholding of a drug for any reason and notify the prescriber."	F 580			

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F 580	<p>Continued From page 13</p> <p>ASM (administrative staff member) #2, the mobile administrator, ASM #1, the interim administration, and ASM #3, the assisted living facility executive director, were made aware of the above concern on 5/2/19 at 10.58 a.m.</p> <p>No further information was provided prior to exit.</p> <p>(1) This information was obtained from the following website: <a href="https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html">https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html</a>.</p> <p>(2) This information was obtained from the following website: <a href="https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100">https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100</a>.</p> <p>2. The facility staff failed to notify the physician when Resident # 12's insulin (1) was administered with blood sugars (1) below 100 (mg/dl [milligram/deciliter]).</p> <p>Resident # 12 was admitted to the facility on 01/21/2019 with diagnoses that included but were not limited to malignant neoplasm of lung (1), depressive disorder (2), diabetes mellitus (3) gastroesophageal reflux disease (4), and convulsions (5).</p> <p>Resident # 12's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/28/19, coded Resident # 12 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions.</p> <p>The physician's order sheet (POS) dated February 2019 for Resident # 12 documented</p>	F 580			

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F 580	<p>Continued From page 14</p> <p>"Novolin (2) (Insulin). Inject 5 units subcutaneously (3) two times a day for diabetes. May hold if blood sugar is less than 100. Order Date: 02/13/2019."</p> <p>The physician's order sheet (POS) dated April 2019 for Resident # 12-documented "Novolin (Insulin). Inject 5 units subcutaneously two times a day for DM (diabetes mellitus) give before breakfast and dinner. May hold if blood sugar is less than 100. Order Date: 03/26/2019."</p> <p>The eMAR (electronic medication administration record) dated February 2019 for Resident # 12 documented the above physician's order. Further review of the eMAR revealed Novolin was administered on 02/15/19 with a blood sugar of 75, on 02/16/19 with blood sugar of 91, 02/20/19 with blood sugar of 85, 02/27/19 with blood sugar of 94 and 77 and on 02/28/19 with blood sugar of 84.</p> <p>The eMAR (electronic medication administration record) dated April 2019 for Resident # 12 documented the above physician's order for insulin. Further review of the eMAR revealed Novolin insulin was administered on 04/16/19 with blood sugar of 91, 04/29/19 with blood sugar of 96 and on 04/30/19 with blood sugar of 69.</p> <p>The comprehensive care plan for Resident # 12 dated 01/21/2019 documented, "Focus. Endocrine System related to; insulin Dependent Diabetes." Under "Interventions" it documented, "Administer medication per physician orders. Date Initiated 01/21/2019."</p> <p>Review of Resident # 12's "Progress Notes" dated February 1, 2019 through February 29,</p>	F 580			

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F 580	<p>Continued From page 15</p> <p>2019 and April 1, 2019 through April 30, 2019 failed to evidence documentation of notification to the physician of insulin administered to the resident with a blood sugar below 100, on the following dates: 02/15/19, 02/16/19, 02/20/19, 02/27/19, 02/28/19, 04/16/19, 04/29/19 and on 04/30/19.</p> <p>On 05/01/19 at 1:15 p.m., an interview was conducted with RN (registered nurse) # 2 unit manager for TSU (transitional step down unit). RN #1 was asked to describe the process staff follows when an insulin is not administered as ordered. RN # 2 stated, "When it is discovered we notify the physician, take the resident's blood sugar, notify the family and resident, follow any additional orders the physician may have, let the physician know what the error is, notify the director of nursing and complete an incident report/medication error report. We investigate the error, how it happened, who was notified and changes in treatment if any, corrections so it doesn't happen again, re-education/training of the staff member. Somebody looks back at the eMAR on a daily basis for blanks, and if the medications and insulin are being administered as ordered. The look back is done by the unit manager and the director of nursing."</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (administrative staff member) # 1, the interim administrator and ASM # 2, mobile administrator, ASM # 3, executive director of the assisted living facility, and ASM # 4, director of nursing were made aware of the findings.</p> <p>No further information was provided prior to exit.</p> <p>References:</p>	F 580			



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F 580	<p>Continued From page 16</p> <p>(1) With type 1 diabetes, your pancreas does not make insulin. Insulin is a hormone that helps glucose get into your cells to give them energy. Without insulin, too much glucose stays in your blood. If you have type 1 diabetes, you will need to take insulin. Type 2 diabetes, the most common type, can start when the body doesn't use insulin as it should. If your body can't keep up with the need for insulin, you may need to take pills. Along with meal planning and physical activity, diabetes pills help people with type 2 diabetes or gestational diabetes keep their blood glucose levels on target. Several kinds of pills are available. Each works in a different way. Many people take two or three kinds of pills. Some people take combination pills. Combination pills contain two kinds of diabetes medicine in one tablet. Some people take pills and insulin. This information was obtained from the website: <a href="https://medlineplus.gov/diabetesmedicines.html">https://medlineplus.gov/diabetesmedicines.html</a>.</p> <p>(2) Blood sugar, or glucose, is the main sugar found in your blood. It comes from the food you eat, and is your body's main source of energy. Your blood carries glucose to all of your body's cells to use for energy. This information was obtained from the website: <a href="https://medlineplus.gov/bloodsugar.html">https://medlineplus.gov/bloodsugar.html</a>.</p> <p>(3) Lung cancer is cancer that starts in the lungs. The lungs are located in the chest. When you breathe, air goes through your nose, down your windpipe (trachea), and into the lungs, where it flows through tubes called bronchi. Most lung cancer begins in the cells that line these tubes. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/007270.htm">https://medlineplus.gov/ency/article/007270.htm</a>.</p>	F 580			

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F 580	Continued From page 17  (4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/003213.htm">https://medlineplus.gov/ency/article/003213.htm</a> .  (5) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/gerd.html">https://www.nlm.nih.gov/medlineplus/gerd.html</a> .  (6) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/003200.htm">https://medlineplus.gov/ency/article/003200.htm</a> .  (7) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/003200.htm">https://medlineplus.gov/ency/article/003200.htm</a> .  (6) Are an immediate-release oral formulation of oxycodone hydrochloride indicated for the management of moderate to severe pain where the use of an opioid analgesic is appropriate. This information was obtained from the website: <a href="https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d48c22ff-bbb4-4a93-a35b-6eebff7b8e53">https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d48c22ff-bbb4-4a93-a35b-6eebff7b8e53</a>	F 580			

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F 580	Continued From page 18  3. The facility staff failed to notify the physician when Resident # 12's insulin was administered with blood sugars were below150.  Resident # 26 was admitted to the facility on 11/22/2016 with diagnoses that included but were not limited to dementia (1), depressive disorder (2), dysphagia (3) and diabetes mellitus (4).  Resident # 26's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/08/19, coded Resident # 26 as scoring a 9 (nine) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 9 (nine) - being moderately impaired of cognition intact for making daily decisions. Resident # 26 was coded as requiring limited assistance of one staff member for activities of daily living.  The physician's order sheet (POS) dated February, March, April 2019 for Resident # 26 documented "Novolog (5). Inject 5 units subcutaneously before meals for DM (diabetes mellitus). Hold for BS (blood sugar) < (less than) 150. Order Date: 11/20/2018."  The eMAR (electronic medication administration record) dated February 2019 for Resident # 26 documented the above physician's order. Further review of the eMAR revealed Novolog insulin was administered on the following dates with a blood sugar reading below 150: -02/01/19 with a blood sugar of 98, - 02/02/19 with a blood sugar of 68, - 02/05/19 with a blood sugar of 129, - 02/08/19 with a blood sugar of 127,	F 580			

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F 580	<p>Continued From page 19</p> <ul style="list-style-type: none"> <li>- 02/09/19 with a blood sugar of 113,</li> <li>- 02/11/19 with a blood sugar of 85,</li> <li>- 02/16/19 with blood a sugar of 97,</li> <li>- 02/20/19 with a blood sugar of 103,</li> <li>- 02/25/19 with a blood sugar of 104.</li> </ul> <p>The eMAR (electronic medication administration record) dated March 2019 for Resident # 26 documented the above physician's order for Novolog insulin. Further review of the eMAR revealed Novolog was administered on the following dates with a blood sugar reading below 150:</p> <ul style="list-style-type: none"> <li>-03/02/19 with a blood sugar of 114,</li> <li>- 03/03/19 with a blood sugar of 93 and 103,</li> <li>-03/05/19 with a blood sugar of 136,</li> <li>-03/10/19 with a blood sugar of 104,</li> <li>- 03/11/19 with a blood sugar of 120 and 88,</li> <li>- 03/16/19 with a blood sugar of 97,</li> <li>- 03/17/19 with a blood sugar of 91,</li> <li>- 03/19/10 with a blood sugar of 135,</li> <li>- 03/21/19 with a blood sugar of 130,</li> <li>- 03/25/19 with a blood sugar of 11 and 144,</li> <li>- 03/29/19 with a blood sugar of 140,</li> <li>-03/30/19 with a blood sugar of 92,</li> <li>- 03/31/19 with a blood sugar of 137.</li> </ul> <p>The eMAR (electronic medication administration record) dated April 2019 for Resident # 26 documented, Novolog. Inject 5 units subcutaneously before meals for DM. Hold for BS &lt; 150." Further review of the eMAR revealed Novolog was administered on the following dates with a blood sugar reading below 150:</p> <ul style="list-style-type: none"> <li>- 04/05/19 with a blood sugar of 112,</li> <li>- 04/08/19 with a blood sugar of 114,</li> <li>- 04/10/19 with a blood sugar of 119,</li> <li>- 04/12/19 with a blood sugar of 98,</li> <li>- 04/13/19 with a blood sugar of 101,</li> </ul>	F 580			

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

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F 580	<p>Continued From page 20</p> <ul style="list-style-type: none"> <li>- 04/16/19 with a blood sugar of 129 and 102,</li> <li>- 04/21/19 with a blood sugar of 101 and 144,</li> <li>- 04/22/19 with a blood sugar of 95,</li> <li>- 04/27/19 with a blood sugar of 72,</li> <li>- 04/29 with a blood sugar of 134,</li> <li>- 04/30/19 with a blood sugar of 109.</li> </ul> <p>The comprehensive care plan for Resident # 12 dated 11/23/2016 documented, "Focus. Endocrine System related to; insulin Dependent Diabetes." Under "Interventions" it documented, "Administer medication per physician orders. Date Initiated 11/23/2016."</p> <p>Review of Resident # 26's "Progress Notes" dated February 1, 2019 through April 30, 2019 failed to evidence documentation that Resident # 26's insulin was not administered as ordered by the physician or that there was notification to the physician insulin was administered when the resident's blood sugar was below 150 on the following dates:</p> <ul style="list-style-type: none"> <li>- 02/01/19, 02/02/19, 02/05/19, 02/08/19, 02/09/19, 02/11/19, 02/16/19, 02/20/19, and on 02/25/19.</li> <li>- On 03/02/19, 03/03/19, 03/05/19, 03/10/19, 03/11/19, 03/16/19, 03/17/19, 03/19/10, 03/21/19, 03/25/19, 03/29/19, 03/30/19 and on 03/31/19.</li> <li>- On 04/05/19, 04/08/19, 04/10/19, 04/12/19, 04/13/19, 04/16/19, 04/21/19, 04/22/19, 04/27/19, 04/29, and on 04/30/19.</li> </ul> <p>On 05/01/19 at 1:15 p.m., an interview was conducted with RN (registered nurse) # 2, unit manager for TSU (transitional step down unit). RN #1 was asked to describe the process staff follows when an insulin is not administered as ordered. RN # 2 stated, "When it is discovered we notify the physician, take the resident's blood</p>	F 580			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/02/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 580	<p>Continued From page 21</p> <p>sugar, notify the family and resident, follow any additional orders the physician may have, let the physician know what the error is, notify the director of nursing and complete an incident report/medication error report. We investigate the error, how it happened, who was notified and changes in treatment if any, corrections so it doesn't happen again, re-education/training of the staff member. Somebody looks back at the eMAR on a daily basis for blanks, and if the medications and insulin are being administered as ordered. The look back is done by the unit manager and the director of nursing."</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (administrative staff member) # 1, the interim administrator and ASM # 2, mobile administrator, ASM # 3, executive director of the assisted living facility, and ASM # 4, director of nursing were made aware of the findings.</p> <p>No further information was provided prior to exit.</p> <p>References: (1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/000739.htm">https://medlineplus.gov/ency/article/000739.htm</a>.</p> <p>(2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/003213.htm">https://medlineplus.gov/ency/article/003213.htm</a>.</p>	F 580			

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F 580	<p>Continued From page 22</p> <p>(3) A swallowing disorder. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html">https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html</a>.</p> <p>(4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm">https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm</a>.</p> <p>(5) A rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. This information was obtained from the website: <a href="https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5">https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5</a>.</p> <p>4. The facility staff failed to ensure the physician was notified Resident #17's diabetic medications were held without an order, or not administered per the physicians orders.</p> <p>Resident #17 was admitted to the facility on 7/27/18, diagnoses included, but are not limited to, diabetes, high blood pressure, atrial fibrillation, dementia with behaviors, depression, and anxiety disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/1/19. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; supervision for transfers, ambulation, dressing, toileting and hygiene; was independent for eating, and was continent of bowel and bladder.</p>	F 580			

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F 580	<p>Continued From page 23</p> <p>FEBRUARY 2019:</p> <p>A review of the clinical record revealed the following physician orders that were in effect for all or part of February 2019:</p> <ul style="list-style-type: none"> <li>- An order dated 2/13/19 for Novolog (1) Flexpen 3 units before meals, hold if blood sugar is below 100. This order was discontinued on 2/27/19.</li> </ul> <p>A review of the February 2019 MAR revealed the following: 2/14/19 - the morning dose of Novolog 3 units was given. The medication was to be held if the blood sugar was less than 100. The resident's blood sugar was 79. There was no evidence of physician notification that the medication was given when the blood sugar was outside of parameters to give the medication. On 2/15/19 - the morning dose of Novolog 3 units was given. The medication was to be held if the blood sugar was less than 100. The resident's blood sugar was 89. There was no evidence of physician notification that the medication was given when the blood sugar was outside of parameters to give the medication. On 2/25/19 - the morning dose of Novolog 3 units was given. The medication was to be held if the blood sugar was less than 100. The resident's blood sugar was 95. There was no evidence of physician notification that the medication was given when the blood sugar was outside of parameters to give the medication.</p> <p>MARCH 2019:</p> <p>A review of the clinical record revealed the</p>	F 580			



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F 580	<p>Continued From page 24</p> <p>following physician orders that were in effect for all or part of March 2019:</p> <p>An order dated 9/4/18 for Lantus (2) 40 units at bedtime. This order was discontinued on 4/18/19.</p> <p>An order dated 2/27/19 for Humalog (3) 6 units before meals. This order was discontinued on 3/5/19.</p> <p>An order dated 3/5/19 for Novolog 6 units before meals. This order remained active as of the survey.</p> <p>A review of the March 2019 MAR revealed the following:</p> <p>On 3/4/19 - lunchtime dose of Humalog 6 units was held. There were no orders or parameters to hold the Humalog. The resident's blood sugar was 92. There was no evidence the physician was notified of the Humalog being held when it was not ordered to be held.</p> <p>On 3/6/19 - the morning Novolog of 6 units was held. There were no orders or parameters to hold the Novolog. The resident's blood sugar was 83. There was no evidence the physician was notified of the Novolog being held when it was not ordered to be held. On 3/10/19 - the morning Novolog of 6 units was held. There were no orders or parameters to hold the Novolog. The resident's blood sugar was 95. There was no evidence the physician was notified of the Novolog being held when it was not ordered to be held. On 3/15/19 - the morning Novolog of 6 units was held. There were no orders or parameters to hold the Novolog. The MAR was coded as "Other/See Nurse Notes." The notes documented the blood sugar was 79. There was no evidence the physician was notified of the Novolog being held when it was not ordered to be</p>	F 580			

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F 580	<p>Continued From page 25 held.</p> <p>On 3/27/19 - no evidence of the Lantus 40 units being administered at bedtime. The MAR was coded as "Other/See Nurse Notes." The notes documented the blood sugar was 72 and rechecked and was 80. There were no orders to hold the Lantus. There was no evidence the physician or nurse practitioner was notified of the medication being held.</p> <p>APRIL 2019:</p> <p>A review of the clinical record revealed the following physician orders that were in effect for all or part of March 2019: An order dated 3/5/19 for Novolog 6 units before meals. This order remained active as of the survey.</p> <p>A review of the April 2019 MAR revealed the following: On 4/3/19 - the morning dose of Novolog 6 units was held. The blood sugar was 117. There were no orders or parameters to hold the Novolog. There was no evidence the physician was notified of the Novolog being held when it was not ordered to be held. On 4/3/19 - the lunchtime dose of Novolog 6 units was held. There was no documented blood sugar. There were no orders or parameters to hold the Novolog. There was no evidence the physician was notified of the Novolog being held when it was not ordered to be held. On 4/11/19 - the lunchtime dose of Novolog 6 units was held. The blood sugar was 99. There were no orders or parameters to hold the Novolog. There was no evidence the physician was notified of the Novolog being held when it</p>	F 580			

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F 580	<p>Continued From page 26 was not ordered to be held.</p> <p>A review of the care plan revealed one dated 7/27/18 for "Endocrine System related to; Insulin Dependent Diabetes." This care plan included the interventions, "Administer medication per physician orders" dated 7/27/18, "Obtain glucometer readings and report abnormalities as ordered" dated 2/12/19, "Obtain Lab [laboratory tests] results as ordered and notify physician of results" dated 7/27/18.</p> <p>On 5/2/19 at 11:06 AM, an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 asked about the above findings of insulins held when there was no parameters or orders to hold it. LPN #1 stated that it should have been administered and if the nurse felt it was not safe to do so, she should notify the physician of the blood sugar and see if the physician wants to hold the dose and write the order for it. LPN #1 stated a nurse cannot hold a medication without an order. When asked about the above findings of insulins administered when there were ordered parameters to hold it, LPN #1 stated that it should have been held and the physician should be notified that it was not held.</p> <p>On 5/02/2019 At 9:25 AM, in an interview with LPN #4, when asked what about the process followed when you hold a medication, LPN #4 stated, "Usually we contact the doctor and the RP (responsible party)."</p> <p>On 5/2/19 at 11:20 AM, ASM #1 (Administrative Staff Member) (Administrator), ASM #2 (Mobile</p>	F 580			

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F 580	<p>Continued From page 27</p> <p>Administrator), ASM #3 (ALF Executive Director) and ASM #4 (Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey.</p> <p>(1) Novolog - Insulin aspart is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. In patients with type 1 diabetes, insulin aspart is usually used with another type of insulin, unless it is used in an external insulin pump. In patients with type 2 diabetes, insulin aspart also may be used with another type of insulin or with oral medication(s) for diabetes. Insulin aspart is a short-acting, manmade version of human insulin. Insulin aspart works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar. Information obtained from <a href="https://medlineplus.gov/druginfo/meds/a605013.html">https://medlineplus.gov/druginfo/meds/a605013.html</a></p> <p>(2) Lantus - Insulin glargine is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes. In people with type 1 diabetes, insulin</p>	F 580			

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F 580	Continued From page 28 glargine must be used with another type of insulin (a short-acting insulin). In people with type 2 diabetes, insulin glargine also may be used with another type of insulin or with oral medication(s) for diabetes. Insulin glargine is a long-acting, manmade version of human insulin. Insulin glargine works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar. Information obtained from <a href="https://medlineplus.gov/druginfo/meds/a600027.html">https://medlineplus.gov/druginfo/meds/a600027.html</a>  (3) Humalog - Insulin lispro is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. In patients with type 1 diabetes, insulin lispro is always used with another type of insulin, unless it is used in an external insulin pump. In patients with type 2 diabetes, insulin lispro may be used with another type of insulin or with oral medication(s) for diabetes. Insulin lispro is a short-acting, manmade version of human insulin. Insulin lispro works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar. Information obtained from <a href="https://medlineplus.gov/druginfo/meds/a697021.html">https://medlineplus.gov/druginfo/meds/a697021.html</a>	F 580			

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F 582	Continued From page 29	F 582			
F 582 SS=D	<p>Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)</p> <p>§483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.</p> <p>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the</p>	F 582 F 582		5/23/19	

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F 582	<p>Continued From page 30</p> <p>facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide notice of Medicare non-coverage for two of 56 residents in the survey sample, Residents #354 and #355.</p> <p>1. Resident #354's last covered day of Medicare Part A services was 11/7/18. The facility staff failed to notify Resident #354 (and/or the resident's representative) of the last covered day and the right to appeal.</p> <p>2. Resident #355's last covered day of Medicare Part A services was 1/21/19. The facility staff failed to notify Resident #355 (and/or the resident's representative) of the last covered day and the right to appeal.</p> <p>The findings include:</p> <p>1. Resident #354's last covered day of Medicare Part A services was 11/7/18. The facility staff</p>	F 582	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p style="text-align: center;">F-582</p> <p>It is the intended practice of this facility to notify the resident and/or the resident's representative of the Medicare non covered days and the right to appeal.</p> <p>1. Resident #354 no longer resides in the facility. Resident #355 was skilled as a</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 582	<p>Continued From page 31</p> <p>failed to notify Resident #354 (and/or the resident's representative) of the last covered day and the right to appeal.</p> <p>Resident #354 was admitted to the facility on 5/9/18. Resident #354's diagnoses included but were not limited to, anxiety disorder and retention of urine. Resident #354's most recent MDS (minimum data set) (prior to discharge), a 30 day Medicare assessment with an ARD (assessment reference date) of 10/31/18, coded the resident's cognitive skills for daily decision-making as moderately impaired.</p> <p>On 5/1/19 at 10:31 a.m., an interview was conducted with OSM (other staff member) #1 (the social worker). OSM #1 stated the facility policy is to issue a notice of Medicare non-coverage two days before a resident is discharged from the facility. OSM #1 stated a notice of Medicare non-coverage always has to be issued 48 hours before discharge from the facility and 24 hours before the skilled services (Medicare Part A) end. OSM #1 confirmed Resident #354's last covered day of Medicare Part A services was 11/7/18 and she could not provide a notice of Medicare non-coverage. OSM #1 stated she had been in this role for a month and could not answer what happened. OSM #1 confirmed a notice should have been completed.</p> <p>On 5/1/19 at 4:15 p.m., ASM (administrative staff member) #2 (the mobile administrator) and ASM #4 (the director of nursing) were made aware of the above concern.</p> <p>On 5/2/19 at 1:05 p.m., OSM #1 stated that she had been in the social services role since the end of March and could show evidence that all notices</p>	F 582	<p>managed care patient, notification was discussed with the patient and family.</p> <p>2. Residents that are covered by Medicare payer have the potential to be affected.</p> <p>3. The social services department was re-educated on the importance of notifying the resident and/or the resident's representative of the Medicare non-covered days and the right to appeal.</p> <p>4. Social Services and/or designee will audit Medicare covered residents for notifications of non-coverage daily x5 days and then 3 days a week x 3 weeks and then monthly x 2 months. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed.</p> <p>5. The facility alleged date of compliance will be June 11, 2019.</p>		



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F 582	<p>Continued From page 32</p> <p>of Medicare non-coverage had been completed since then. When asked if the facility had an action plan in place, OSM #1 stated she did not believe a plan was started and could not show evidence of a corrective action plan.</p> <p>The facility document titled, "Notice of Medicare Non Coverage Policy &amp; Process (NOMNC): Medicare Advantage Patients" documented, "No later than two (2) calendar days prior to the termination of skilled services, a Notice of Medicare Non Coverage ('NOMNC') has to be delivered to the patient and/or the patient's representative or responsible party (both collectively referred to in this policy as 'RP'). The NOMNC must be signed by the enrollee or the RP and dated on the date that he or she signs the NOMNC. If the NOMNC is delivered, but the enrollee or RP refuses to sign on the delivery date, the (name of facility) representative should note in the case file the date on which the NOMNC was delivered."</p> <p>No further information was presented prior to exit.</p> <p>2. Resident #355's last covered day of Medicare Part A services was 1/21/19. The facility staff failed to notify Resident #355 (and/or the resident's representative) of the last covered day and the right to appeal.</p> <p>Resident #355 was admitted to the facility on 6/30/17. Resident #355's diagnoses included but were not limited to heart failure and muscle weakness. Resident #355's most recent MDS (minimum data set) (prior to discharge), a quarterly assessment with an ARD (assessment reference date) of 4/3/19, coded the resident as being cognitively intact.</p>	F 582			

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F 582	Continued From page 33  On 5/1/19 at 10:31 a.m., an interview was conducted with OSM (other staff member) #1 (the social worker). OSM #1 stated the facility policy is to issue a notice of Medicare non-coverage two days before a resident is discharged from the facility. OSM #1 stated a notice of Medicare non-coverage always has to be issued 48 hours before discharge from the facility and 24 hours before the skilled services (Medicare Part A) end. OSM #1 confirmed Resident #355's last covered day of Medicare Part A services was 1/21/19 and she could not provide a notice of Medicare non-coverage. OSM #1 stated she had been in this role for a month and could not answer what happened. OSM #1 confirmed a notice should have been completed.  On 5/1/19 at 4:15 p.m., ASM (administrative staff member) #2 (the mobile administrator) and ASM #4 (the director of nursing) were made aware of the above concern.  On 5/2/19 at 1:05 p.m., OSM #1 stated that she had been in the social services role since the end of March and could show evidence that all notices of Medicare non-coverage had been completed since then. When asked if the facility had an action plan in place, OSM #1 stated she did not believe a plan was started and could not show evidence of a corrective action plan.	F 582			
F 584 SS=D	No further information was presented prior to exit. Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)  §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		5/23/19	

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F 584	<p>Continued From page 34</p> <p>comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide-</p> <p>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 584			

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F 584	<p>Continued From page 35</p> <p>Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide a homelike environment for one of 56 residents in the survey sample, Resident #58.</p> <p>Resident #58's room failed to provide a homelike environment as she only had a bed and over bed table. There was no other furniture on her side of the room.</p> <p>The findings include:</p> <p>Resident #58 was admitted to the facility 11/29/18 with diagnoses that included but were not limited to: cerebral palsy [A group of disorders that affect a person's ability to move and to maintain balance and posture (1)], intellectual disability [Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness (2)] and high blood pressure.</p> <p>The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/6/19, coded the resident as having both short and long-term memory difficulties and as moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for most of her activities of daily living and was coded as being dependent upon the staff for toileting and personal hygiene.</p>	F 584	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p style="text-align: center;">F-584</p> <p>It is the intended practice of this facility to provide a safe, clean, comfortable and homelike environment.</p> <ol style="list-style-type: none"> <li>1. Upon notification from the surveyor on May 1, 2019, resident #58 was immediately provided a night stand. Resident rooms were audited for night stands.</li> <li>2. Residents who reside in the facility have the potential to be affected.</li> <li>3. Staff will be re-educated on the importance to providing a homelike environment with required furnishings in resident's rooms.</li> <li>4. Administrator and/or designee will randomly audit 22 resident rooms for required furnishings daily x 5 days, and three days a week x 3 weeks and then monthly x 2 months. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will</li> </ol>		

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F 584	<p>Continued From page 36</p> <p>Observation was made of Resident #58's room on 4/30/19, at approximately 11:40 a.m.; Resident #58 was in her bed, awake. Resident #58 could only answer to her name. There was no nightstand or over bed table at this time. The room appeared bare and institutionalized. There was nothing on the walls and no nightstand to put her belongings on. The other resident in the room had a nightstand and an over bed table. The closet and dresser drawers were located at the foot of the bed on the other side of the room from Resident #58.</p> <p>A second observation was made of Resident #58's room on 4/30/19 at 3:47 p.m. The resident was in the bed. There was an over bed table next to the bed but no nightstand.</p> <p>An interview was conducted with CNA (certified nursing assistant) #4 on 5/1/19 at 1:14 p.m. When asked why Resident #58 did not have a nightstand, CNA #4 stated, "I've asked for one but I will have to check on that and get back with you." When asked if Resident #58 should have a nightstand, CNA #4 stated, "Yes, Ma'am." CNA #4 showed where Resident #58's two drawers, closet space and basin with her personal belongings was located in the wall unit on the other side of the room.</p> <p>An interview was conducted with LPN (licensed practical nurse) # 4 on 5/1/19 at 1:19 p.m. When asked if every resident should have an over bed table and a night stand, LPN #4 stated, "Yes, I believe so." When asked why Resident #58 does not have a night stand, LPN #4 stated, "We are working on that right now."</p> <p>An interview was conducted with administrative</p>	F 584	<p>be discussed and implemented as needed.</p> <p>5. The facility alleged date of compliance is June 11, 2019.</p>		

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F 584	Continued From page 37 staff member (ASM) #2, the mobile administrator, on 5/1/19 at 1:23 p.m. When asked if every resident should have an over bed table and a night stand, ASM #2 stated, "Yes."  The facility policy, "Respect/Dignity/Right to have Personal Property" documented in part, "Resident's possessions, regardless of their apparent value to others, must be treated with respect. Resident have the right to retain and use personal possessions to promote a homelike environment and support each resident in maintaining their independence."  ASM #2, ASM #1, the interim administration, and ASM #3, the assisted living facility executive director, were made aware of the above concern on 5/2/19 at 10.58 a.m.  No further information was provided prior to exit.  (1) This information was obtained from the following website: <a href="https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html">https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html</a> ,  (2) This information was obtained from the following website: <a href="https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100">https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100</a>	F 584			
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)  §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or	F 622			5/23/19

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F 622	Continued From page 38 discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.  §483.15(c)(2) Documentation.	F 622			

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F 622	<p>Continued From page 39</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical record must include:</p> <p>(A) The basis for the transfer per paragraph (c)(1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and</p>	F 622			



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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 622	<p>Continued From page 40</p> <p>any other documentation, as applicable, to ensure a safe and effective transition of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure the required documentation was provided to the receiving facility at the time of a transfer for one of 56 residents in the survey sample, Resident # 48.</p> <p>The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for Resident # 48's facility-initiated transfer to the hospital on 04/18/19.</p> <p>The findings include:</p> <p>Resident # 48 was admitted to the facility on 09/27/2018 and a readmission on 02/15/2019 with diagnoses that included but were not limited to heart failure (1), chronic obstructive pulmonary disease (2), and anemia (3).</p> <p>Resident # 48's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/22/2019, coded Resident # 48 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions.</p> <p>The nurse's "Progress Notes," dated 04/18/2019 for Resident # 48 documented, "01:11 (1:11 a.m.) Received resident in hallway, confused, leaning on left side, ambulating with unsteady gait, to exit doors/long hall/short setting off [sic] firearm [sic]</p>	F 622	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p style="text-align: center;">F-622</p> <p>It is the intended practice of this facility to provide evidence that a resident's documentation and information was provided to a receiving provider upon a facility initiated transfer to a hospital.</p> <ol style="list-style-type: none"> <li>1. Resident #48 no longer resides in the facility.</li> <li>2. Residents that the facility initiated a transfer to the hospital have the potential to be affected.</li> <li>3. Licensed Nurses were re-educated on the Acute Care Transfer Documentation Checklist, in order to make sure to provide written documentation to the receiving provider upon a facility initiated transfer to a hospital.</li> </ol>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/02/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
(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 622	<p>Continued From page 41</p> <p>arms. Easily redirected but short lived. Received critical ammonia level at 99H [high]. MD (medical doctor) office called with lab (laboratory) results, order obtained to send resident to ER (emergency room). RP (responsible party) made aware. 911 called and resident was picked up 1:15 AM for ER [name of hospital]."</p> <p>Review of the clinical record and the EHR (electronic health record) for Resident # 48 failed to evidence documentation that Resident # 48's contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, Advance Directive information, all special instructions or precautions for ongoing care, as appropriate, comprehensive care plan goals, all other necessary information, including a copy of the resident's discharge summary was provided to the receiving facility at the time of Resident # 48's transfer to the hospital on 04/18/2019.</p> <p>On 05/01/19 at 5:00 p.m., a request was made to ASM (administrative staff member) # 2, mobile administrator and ASM # 4, the director of nursing, for the required documentation regarding Resident # 48's transfer to the hospital on 4/18/19.</p> <p>On 05/02/19 at 8:05 a.m., ASM # 4, director of nursing stated they did not have the checklist of documentation sent to the receiving facility for Resident # 48's transfer to the hospital on 4/18/19.</p> <p>On 5/2/19 at 11:54 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked to describe the information provided to</p>	F 622	<p>4. Director of Nursing and/or designee will audit written documentation for any acute care transfer daily x 5 days, then 3 days a week x 3 weeks and then monthly x 2 months. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed.</p> <p>5. The facility alleged date of compliance is June 11, 2019.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/02/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 622	<p>Continued From page 42</p> <p>hospital staff when a resident is transferred to the hospital. RN #1 stated, "We provide them with the situation going on; background information, vital signs, really anything pertinent to what's going on; why we are sending the patient." RN #1 confirmed the nurses provide physician contact information, resident representative contact information, special instructions for providing ongoing care, and comprehensive care plan goals to the hospital staff. When asked how nurse's evidence this information is provided for each resident's hospital transfer, RN #1 stated the information is documented in a progress note. When asked if the progress note should document each item that is provided, RN #1 stated she thought the verbiage written is that the transfer checklist or transfer information was sent, but some nurse's document each item sent. RN #1 was asked if nurses are supposed to send every item documented on the transfer checklist. RN #1 stated, "For the most part, yes. If available, yes." RN #1 was asked if the nurses are supposed to check off each item on the transfer checklist and retain a copy of the checklist. RN #1 stated, "Yes. That's the process." RN #1 was asked how nurses can evidence the information on the checklist is provided for each transfer if there is no copy of the checklist in the clinical record. RN #1 stated, "I don't guess you can." RN #1 stated sometimes the resident's acuity level is an emergent situation but the information should be in a progress note if a copy of the checklist cannot be found.</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (administrative staff member) # 1, the interim administrator and ASM # 2, mobile administrator, ASM # 3, executive director of the assisted living facility, and ASM # 4, director of nursing were</p>	F 622			

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 622	Continued From page 43 made aware of the findings.  No further information was provided prior to exit.  References: (1) A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/000158.htm">https://medlineplus.gov/ency/article/000158.htm</a> .  (2) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/copd.html">https://www.nlm.nih.gov/medlineplus/copd.html</a> .  (3) Low iron. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/anemia.html">https://www.nlm.nih.gov/medlineplus/anemia.html</a> .	F 622			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)  §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F 623		5/23/19	

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 623	<p>Continued From page 44</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in</p>	F 623			

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 623	<p>Continued From page 45</p> <p>completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §</p>	F 623			

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F 623	<p>Continued From page 46 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide the required notifications of a transfer for one of 56 residents in the survey sample, Resident # 48.</p> <p>The facility staff failed to provide Resident # 48 and the Resident # 48's representative written notification and failed to notify the ombudsman of a facility-initiated transfer on 04/18/19 for Resident # 48.</p> <p>The findings include:</p> <p>Resident # 48 was admitted to the facility on 09/27/2018 and readmitted on 02/15/2019 with diagnoses that included but were not limited to heart failure (1), chronic obstructive pulmonary disease (2), and anemia (3).</p> <p>Resident # 48's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/22/2019, coded Resident # 48 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions.</p> <p>The nurse's "Progress Notes," dated 04/18/2019 for Resident # 48 documented, "01:11 (1:11 a.m.) Received resident in hallway, confused, leaning on left side, ambulating with unsteady gait, to exit doors/long hall/short setting off [sic] firearm [sic] arms. Easily redirected but short lived. Received critical ammonia level at 99H. MD (medical doctor) office called with lab (laboratory) results,</p>	F 623	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p style="text-align: center;">F-623</p> <p>It is the intended practice of this facility to provide written notification of a transfer/discharge to the resident, representative, and the Ombudsman.</p> <ol style="list-style-type: none"> <li>1. Resident #48 no longer resides in the facility.</li> <li>2. Residents that the facility initiated a transfer to the hospital have the potential to be affected.</li> <li>3. Licensed Nurses were re-educated on the Acute Care Transfer Documentation Checklist, in order to make sure that they provide written notification to the resident's responsible party upon a facility initiated transfer to a hospital.</li> <li>4. Director of Nursing and/or designee will audit written notification to the</li> </ol>		

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 623	<p>Continued From page 47</p> <p>order obtained to send resident to ER (emergency room). RP (responsible party) made aware. 911 called and resident was picked up 1:15 AM for ER (name of hospital)."</p> <p>Review of the clinical record and the EHR (electronic health record) for Resident # 48 failed to evidence documentation that Resident # 48 and Resident # 48's representative was provided written notification or notification to the ombudsman of Resident # 48's facility initiated transfer to the hospital on 04/18/2019.</p> <p>On 05/01/19 at 5:00 p.m., a request was made to ASM (administrative staff member) # 2, mobile administrator and ASM # 2, the director of nursing, for the required notifications regarding Resident # 48's transfer to the hospital on 4/18/19.</p> <p>On 05/02/19 at 8:05 a.m., ASM # 4, director of nursing stated they did not have the required notifications regarding Resident # 48's transfer to the hospital on 4/18/19.</p> <p>On 5/2/19 at 11:44 p.m., an interview was conducted with ASM (administrative staff member) #3 (the assisted living facility executive director). ASM #3 stated she completes a monthly notification of resident discharges to the ombudsman via fax. ASM #3 stated the list faxed to the ombudsman is pulled from the list of residents who are discharged from the facility. ASM #3 confirmed a resident transferred to the hospital, with return on the same day would not be documented on the list faxed to the ombudsman. ASM #3 reviewed the April 2019 list faxed to the ombudsman and confirmed Resident #48 was not on the list.</p>	F 623	<p>resident's responsible party for any acute care transfers daily x 5 days and then 3 days a week x 3 weeks and then monthly x 2 months. Social Services and/or designee will audit written notification to the ombudsman for any acute care transfer to the hospital daily x 5 days, and then 3 days a week x 3 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated.</p> <p>5. The facility alleged date of compliance is June 11, 2019.</p>		



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F 623	Continued From page 48  On 5/2/19 at 11:54 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 confirmed resident/resident representative transfer notification is an item listed on the transfer checklist. RN #1 was asked if the nurses are supposed to check off each item on the transfer checklist and retain a copy of the checklist. RN #1 stated, "Yes. That's the process." RN #1 was asked how nurses can evidence the information on the checklist is provided for each transfer if there is no copy of the checklist in the clinical record. RN #1 stated, "I don't guess you can." RN #1 stated sometimes the resident's acuity level is an emergent situation but the information should be in a progress note if a copy of the checklist cannot be found.  On 05/02/19 at approximately 3:30 p.m., ASM (administrative staff member) # 1, the interim administrator and ASM # 2, mobile administrator, ASM # 3, executive director of the assisted living facility, and ASM # 4, director of nursing were made aware of the findings.  No further information was provided prior to exit.  References: (1) A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/000158.htm">https://medlineplus.gov/ency/article/000158.htm</a> .  (2) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/copd.html">https://www.nlm.nih.gov/medlineplus/copd.html</a> .	F 623			

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F 623	Continued From page 49	F 623			
F 641 SS=D	<p>(3) Low iron. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/anemia.html">https://www.nlm.nih.gov/medlineplus/anemia.html</a></p> <p>Accuracy of Assessments CFR(s): 483.20(g)</p> <p>§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. 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 ensure a complete and accurate MDS (minimum data set) assessment for two of 56 residents in the survey sample, Resident #66 and Resident #65.</p> <p>1. The facility staff failed to accurately code a BIMS (brief interview for mental status) assessment for Resident #66 on the quarterly MDS (minimum data set), assessment, with an ARD (assessment reference date) of 3/12/19.</p> <p>2. The facility staff failed to ensure Resident # 65's MDS, a quarterly review assessment with an ARD (assessment reference date) of 03/12/19 was complete and accurate. Section C and section D of the assessment had columns marked with dashes [-] instead of numbers.</p> <p>The findings include:</p> <p>1. Resident #66 was admitted to the facility on 12/4/2018. Diagnoses included but were not limited to: chronic diastolic heart failure (1),</p>	F 641	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p style="text-align: center;">F-641</p> <p>It is the intended practice of the facility that the assessments accurately reflect the resident's status.</p> <p>1. Resident #66 and Resident #65 still reside in the facility.</p> <p>2. Residents that have minimum data set assessments have the potential to be affected.</p>	5/23/19	

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 641	<p>Continued From page 50</p> <p>anemia, unsteadiness on feet and peripheral vascular disease (2).</p> <p>The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 3/12/19 failed to complete a BIMS assessment (BIMS assess a residents cognitive ability to make daily decisions) for Resident #66. Section C 0100 failed to code whether a BIMS should be conducted. Section C 0600 failed to code whether Resident #66's metal status should be assessed.</p> <p>On 05/02/19 at approximately 09:51 a.m., a group interview was conducted with RN (registered nurse) #3, MDS coordinator, RN #4 RN, MDS coordinator, and OSM (other staff member) #3, social services. When asked what an MDS is, the facility staff stated, "An MDS is an assessment of the resident." When asked who ensures the accuracy of an MDS assessment. RN #3 replied, "We have a multi-disciplined approach different departments are responsible for different areas of the MDS. The different areas turn green when they are complete, then I can go in and finalize it." A group observation was made of Resident #66's most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 3/12/19. When asked what type of MDS was completed for Resident #66. RN #3 and RN #4 replied, "It is a quarterly." When asked who is responsible for the completion of the BIMS assessment. RN #3 replied, "Social services." When asked should there have been a BIMS assessment for resident. The facility staff replied, "Yes." When asked why a BIMS assessment was not completed. OSM #3 replied, "I came here in March, and I saw that the previous social worker did not complete it by the</p>	F 641	<p>3. Minimum Data Set staff, social services, and the Interdisciplinary Team (IDT) were re-educated on ensuring that all residents are assessed timely and are coded correctly.</p> <p>4. Administrator and/or designee will audit MDSs daily x 5 days, then 3 days a week x 3 weeks and the monthly x 2 months. The results of the random audits will be reported to the QAA committee for review and follow up recommendations as indicated.</p> <p>5. The facility alleged date of compliance is June 11, 2019.</p>		

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F 641	<p>Continued From page 51</p> <p>ARD. So, I did it, and put it in a progress note. I'll print it off and bring it to you."</p> <p>On 05/02/19 at approximately 10:00 a.m., social services note, dated 3/13/19 was reviewed with OSM #3. The social services note documented in part, "SS Quarterly ARD 3/12/19: SW (social work) met with patient this date to complete quarterly assessment. Patient was alert, verbal, and cooperative. Patient scored a BIM of 12, indicating moderate cognitive impairment."</p> <p>On 05/02/19 at approximately 10:01 a.m., an interview was conducted with OSM #3. When asked if a MDS assessment can be modified. OSM #3 stated, "I don't think so."</p> <p>On 05/02/19 at approximately 10:05 a.m., a follow up interview was conducted with RN #3 MDS coordinator. RN #3 was asked if a MDS assessment could be modified. RN #3 stated, "Yes, when there is a significant correction that needs to take place or there was an error in the MDS." When asked if Resident #66's quarterly MDS assessment with an ARD of 3/12/19 should be modified to code her BIMS assessment. RN #3 replied, "No, not for a BIMS, we wrote a note that should be enough." When asked what policies or procedures are used to complete an MDS assessment. RN #3 replied, "The RAI (resident assessment instrument) manual."</p> <p>On 05/02/19 at approximately 1:00 p.m., ASM (administrative staff member) #1, the Interim Administrator, ASM #2, the Mobile Administrator and ASM #3, the Assisted Living Facility (ALF) Executive Director were made aware of the findings.</p>	F 641			

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F 641	<p>Continued From page 52</p> <p>RAI Manual October 2018 - Coding Instructions for Section C0100</p> <p>Should Brief Interview for Mental Status Be Conducted? Item Rationale Health-related Quality of Life o Most residents are able to attempt the Brief Interview for Mental Status (BIMS). o A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance. - Without an attempted structured cognitive interview, a resident might be mislabeled based on his or her appearance or assumed diagnosis. - Structured interviews will efficiently provide insight into the resident's current condition that will enhance good care.</p> <p>Planning for Care o Structured cognitive interviews assist in identifying needed supports. o The structured cognitive interview is helpful for identifying possible delirium behaviors (C1310).</p> <p>Coding Instructions o Code 0, no: if the interview should not be conducted because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status.</p> <p>CMS's RAI Version 3.0 Manual CH 3: MDS Items [C] October 2018 Page C-2 C0100: Should Brief Interview for Mental Status Be Conducted? (cont.) o Code 1, yes: if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words.</p> <p>RAI Manual October 2018 - Errors Identified After the Encoding Period</p> <p>Errors identified after the encoding and editing period must be corrected within 14 days after identifying the errors. If the record in error is an</p>	F 641			

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F 641	<p>Continued From page 53</p> <p>Entry tracking record, Death in Facility tracking record, Discharge assessment, or PPS assessment record (i.e., MDS Item A0310A = 99), then the record should be corrected and submitted to the QIES ASAP system. The correction process may be more complex if the record in error is an OBRA comprehensive or Quarterly assessment record (i.e., Item A0310A = 01 through 06). Significant versus Minor Errors in a Nursing Home OBRA Comprehensive or Quarterly Assessment Record. OBRA comprehensive and Quarterly assessment errors are classified as significant or minor errors. Errors that inaccurately reflect the resident's clinical status and/or result in an inappropriate plan of care are considered significant errors. All other errors related to the coding of MDS items are considered minor errors. If the only errors in the OBRA comprehensive or Quarterly assessment are minor errors, then the only requirement is for the record to be corrected and submitted to the QIES ASAP system.</p> <p>No further information was obtained prior to exit.</p> <p>1. Heart failure (HF) can be defined as the inability of the heart to provide sufficient forward output to meet the perfusion and oxygenation requirements of the tissues while maintaining normal filling pressures. There are two major cardiac mechanisms by which this can occur. ?Systolic dysfunction, in which there is impaired cardiac contractile function ?Diastolic dysfunction, in which there is abnormal cardiac relaxation, stiffness or filling This information was obtained from the website: <a href="https://www.uptodate.com/contents/pathophysiology-of-heart-failure-with-preserved-ejection-fraction?search=diastolic%20heart%20failure&amp;source=s">https://www.uptodate.com/contents/pathophysiology-of-heart-failure-with-preserved-ejection-fraction?search=diastolic%20heart%20failure&amp;source=s</a></p>	F 641			

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F 641	<p>Continued From page 54</p> <p>earch_result&amp;selectedTitle=2~150&amp;usage_type=default&amp;display_rank=2</p> <p>2. The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/vasculardisases.html">https://www.nlm.nih.gov/medlineplus/vasculardisases.html</a>.</p> <p>2. The facility staff failed to ensure Resident # 65's MDS, a quarterly review assessment with an ARD (assessment reference date) of 03/12/19 was complete and accurate. Section C and section D of the assessment had columns marked with dashes [-] instead of numbers.</p> <p>Resident # 65 was admitted to the facility on 01/13/11, with a most recent readmission on 08/13/13, with diagnoses that included but were not limited to hypertension (1), diabetes mellitus (2), and major depressive disorder (3).</p> <p>Resident # 65's most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 03/12/19, coded Resident #65 as scoring a [dash] on the brief assessment for mental status (BIMS) of a score of 0 - 15. A progress note dated 3/13/19 documented by OSM (other staff member) #3, social service director, indicated a BIMS score of 12, 12 indicating moderate cognitive impairment for daily decision making. Resident # 65 was coded as requiring extensive assistance of one</p>	F 641			

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F 641	<p>Continued From page 55</p> <p>staff member for activities of daily living and independent with eating.</p> <p>On 05/1/19, a review of Resident #65's clinical record revealed that the most recent MDS, a quarterly assessment dated 03/12/19, which was marked as accepted, was incomplete. Section C and section D had columns marked with dashes [-] instead of numbers.</p> <p>On 05/02/19 at 9:51 a.m., an interview was conducted with RN (registered nurse) #3 MDS coordinator. When asked the purpose of an MDS assessment, RN #3 stated, "An evaluation tool for resident assessment." When asked when it should be done, RN #3 stated, "It should be administered based on the type: five day, 14 day, quarterly, annually, or when there are a significant change in resident's status." When asked who is responsible for ensuring all parties involved complete their section of the MDS assessment, RN #3 stated, "The MDS team does but social service is responsible for section C and section D."</p> <p>On 05/02/19 10:04 a.m., an interview conducted with OSM (other staff member) #3, social service director. When asked her role in filling out the MDS assessment, OSM #3 stated, "We are responsible for sections C, D, E, Q, and sometimes B." When asked what the dashes [-] meant on Resident #65's clinical record revealed that the most recent MDS, a quarterly assessment dated 03/12/19, OSM #3 stated, "Not assessed, there was no social worker in house that day so I did the BIMS on a different date and entered it in the resident's progress note." When asked if she tried to modify the MDS assessment to enter her assessment, after it was submitted,</p>	F 641			



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F 641	<p>Continued From page 56</p> <p>OSM #3 stated, "No, I don't know how to do that." When asked what reference or policy the facility follows for MDS assessments, OSM #3 stated, "The RAI (Resident Assessment Instrument) manual."</p> <p>The Resident Assessment Manual 3.0, version 1.16, October 2018, pg. 2-43 documents the following in part: "There may be situations when an assessment might be delayed (e.g., illness of RN assessor, a high volume of assessments due at approximately the same time) or additional days are needed to more fully capture therapy or other treatments. Therefore, CMS has allowed for these situations by defining a number of grace days for each Medicare assessment ...The use of grace days allows clinical flexibility in setting ARDs".</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (Administrative Staff Member) #2, the mobile administrator, and ASM #4, the director of nursing, were made aware of the above findings.</p> <p>No further information was provided prior to exit.</p> <p>References:</p> <ol style="list-style-type: none"> <li>1. High blood pressure. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/highbloodpressure.html">https://www.nlm.nih.gov/medlineplus/highbloodpressure.html</a>.</li> <li>2. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/ency/article/">https://www.nlm.nih.gov/medlineplus/ency/article/</a></li> </ol>	F 641			

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F 641	Continued From page 57 001214.htm.  3. Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/003213.htm">https://medlineplus.gov/ency/article/003213.htm</a> .	F 641			
F 645 SS=D	PASARR Screening for MD & ID 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	F 645		5/23/19	

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F 645	<p>Continued From page 58</p> <p>condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.</p> <p>§483.20(k)(2) Exceptions. For purposes of this section-</p> <p>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.</p> <p>(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-</p> <p>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,</p> <p>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and</p> <p>(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.</p> <p>§483.20(k)(3) Definition. For purposes of this section-</p> <p>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).</p> <p>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3)</p>	F 645			

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F 645	<p>Continued From page 59</p> <p>or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure one of 56 residents in the survey sample, (Resident #93) had a completed Level I PASARR (preadmission screening and resident review).</p> <p>The facility staff failed to have a Level I PASARR completed for Resident #93, to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs.</p> <p>The findings include:</p> <p>Resident #93 was admitted to the facility on 8/18/17 with a recent readmission on 3/27/18, with diagnoses that included but were not limited to: dementia, psychosis [major mental disorder in which the person is usually detached from reality and has impaired perceptions, thinking, responses and interpersonal relationships (1)], diabetes and high blood pressure.</p> <p>The most recent MDS (minimum data set) assessment with an assessment reference date of 4/3/19, coded the resident as scoring a "1" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance for most of his activities of daily living.</p> <p>Review of the clinical record failed to evidence a Level I PASARR.</p>	F 645	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p style="text-align: center;">F-645</p> <p>It is the intended practice of the facility to ensure that a level 1 PASARR is completed.</p> <ol style="list-style-type: none"> <li>1. Resident #93 resides in the facility. A level 1 PASARR was completed prior to exit of the survey team.</li> <li>2. Residents that are admitted to the facility have the potential to be affected.</li> <li>3. Admission Department and Social Services Department were re-educated to ensure level 1 PASARRs are completed.</li> <li>4. Admission Director and/or designee will audit residents who are required to have PASARRs to ensure that level 1 PASARRs are completed daily x 5 days and then 3 days a week x 3 weeks and then monthly x 2 months. The results of</li> </ol>		

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F 645	<p>Continued From page 60</p> <p>A request was made on 5/1/19 at approximately 5:00 p.m. for a copy of the PASARR. ASM #2, the mobile administrator, was given the list.</p> <p>A copy of a PASARR was presented on 5/2/19 at approximately 8:00 a.m. The copy presented for review was signed and dated on 5/1/19.</p> <p>On 5/2/19 at 8:28 a.m., an interview was conducted with other staff member (OSM) #2, the admissions director, the one that signed the form above. When asked if Resident #93 had a previous PASARR completed prior to 5/1/19, OSM #2 stated, "No, not that we had on file or in his record." When asked the process to ensure every resident who needs a Level I PASARR has one completed, OSM #2 stated the facility will request it from the hospital social worker. If we are unable to obtain one there, we call their locality (Local County) to see if they have one on file. If they do not have one, we complete it here." It's supposed to be completed during the admissions process." When asked what happened with Resident #93, OSM #2 stated, "We don't check one every time for readmissions, it's usually checked on the initial admission."</p> <p>The facility policy, "PASARR Screening for Mental Disorder (MD) &amp; Intellectual Disability (ID)." documented in part, "The PASARR process requires that all applicants to Medicaid-certified nursing facilities be screened for possible serious mental disorders, intellectual disabilities and related conditions. The initial screening is referred to a Level I Identification of individuals with MD or ID and is completed prior to admission to a nursing facility. The purpose of the Level I pre-admission screening is to identify individuals</p>	F 645	<p>the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated.</p> <p>5. The facility alleged date of compliance is June 11, 2019.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/02/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 645	Continued From page 61 who have or may have MD/ID or a related condition, who would then require PASARR, which must be conducted prior to admission to the facility. Failure to pre-screen residents prior to admission to the facility may result in the failure to identify resident who have or may have MD, ID or a related condition. A record of the prescreening should be retained in the resident's medical record."  ASM (administrative staff member) #2, the mobile administrator, ASM #1, the interim administration, and ASM #3, the assisted living facility executive director, were made aware of the above concern on 5/2/19 at 10.58 a.m.  No further information was provided prior to exit.  (1) This information was obtained from the following website: <a href="https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html">https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html</a> .	F 645			
F 656 SS=E	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	F 656		5/23/19	

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F 656	<p>Continued From page 62</p> <p>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 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.</p> <p>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 develop and/or implement the comprehensive care plan for six of 56 residents in the survey sample, Residents #93, #26, #12, #17, #127, #72.</p> <p>1. The facility staff failed to implement Resident #93's comprehensive care plan related to the resident's diabetes.</p>	F 656	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or</p>		

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F 656	<p>Continued From page 63</p> <p>2. The facility staff failed to implement the comprehensive care plan for the administration of insulin (1) for Resident # 26.</p> <p>3. The facility staff failed to implement the comprehensive care plan for the administration of insulin (1) for Resident # 12.</p> <p>4. The facility staff failed to implement Resident #17's comprehensive care plan for the administration of diabetic medications.</p> <p>5. The facility staff failed to develop a comprehensive care plan to address Resident #127's oxygen use.</p> <p>6. The facility staff failed to implement Resident #72's comprehensive care plan for the administration of oxygen.</p> <p>The findings include:</p> <p>1. The facility staff failed to implement Resident #93's comprehensive care plan related to the resident's diabetes.</p> <p>Resident #93 was admitted to the facility on 8/18/17 with a recent readmission on 3/27/18, with diagnoses that included but were not limited to: dementia, psychosis [major mental disorder in which the person is usually detached from reality and has impaired perceptions, thinking, responses and interpersonal relationships (1)], diabetes and high blood pressure.</p> <p>The most recent MDS (minimum data set) assessment with an assessment reference date of 4/3/19, coded the resident as scoring a "1" on</p>	F 656	<p>will be corrected by the date or dates indicated.</p> <p>F-656 It is the intended practice of the facility to develop and implement a comprehensive person-centered care plan for each resident.</p> <p>1. Residents #93, #26, #12, #17, #127 and #72 comprehensive care plans were reviewed and addressed prior to exit of survey.</p> <p>2. Residents who receive insulin and/or oxygen and reside in the facility have the potential to be affected.</p> <p>3. Licensed Nurses and the Interdisciplinary Team (IDT) were re-educated on the development and implementation of comprehensive person-centered care plan for each resident who receive insulin and/or oxygen.</p> <p>4. Director of Nursing and/or designee will audit care plans for residents with new orders for insulin and/or oxygen daily x 5 days and then 3 days a week x 3 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated.</p> <p>5. The facility alleged date of compliance is June 11, 2019.</p>		



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F 656	<p>Continued From page 64</p> <p>the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance for most of his activities of daily living. In Section N - Medications, the resident was coded as receiving five days of insulin injections during the look back period.</p> <p>The comprehensive care plan dated, 8/18/17, documented in part, "Focus: Insulin therapy to treat DM2 (diabetes mellitus type two). At risk for adverse effects." The "Interventions" documented, "Educate/review current medication, reason for use &amp; (and) administration needs with patient &amp;/or family. Report signs &amp; symptoms of adverse reactions."</p> <p>The physician order dated, 3/27/19, documented, "Insulin Glargine Solution (Lantus) inject 10 unit subcutaneously at bedtime for dm (diabetes mellitus)."</p> <p>The April 2019 MAR (medication administration record) documented the above physician order. On the following dates, the MAR documented the medication as not administered as ordered: 4/5/19 - a "6" was documented. (The code on the MAR for a "6" was "no insulin per order.") - The resident's blood sugar was documented as "97." 4/6/19 - a "6" was documented. The resident's blood sugar was documented as "96." 4/7/19 - a "6" was documented. The resident's blood sugar was documented as "98." 4/14/19 - a "9" was documented. (The code on the MAR for a "9" was "see progress note"). The resident's blood sugar was not documented. 4/16/19 - a "9" was documented. The resident's blood sugar was not documented.</p>	F 656			

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 656	<p>Continued From page 65</p> <p>4/18/19 - a "6" was documented. The resident's blood sugar was documented as "106."</p> <p>4/22/19 - a "6" was documented. The resident's blood sugar was documented as "68."</p> <p>4/23/19 - a "6" was documented. The resident's blood sugar was documented as "114."</p> <p>4/24/19 - a "6" was documented. The resident's blood sugar was documented as "98."</p> <p>Review of the nurse's notes for the month of April failed to evidence any documentation of the reason why the insulin was held, notifying the doctor and the responsible party except on 4/16/19 at 11:58 p.m. the nurse documented, "BS (blood sugar) - 88 Held insulin tonight."</p> <p>On 5/2/19 at 9:25 a.m., an interview was conducted with LPN (licensed practical nurse) # 4 (one of the nurse's that held the above ordered insulin). When asked what Lantus is, LPN #4 stated, "Insulin, long acting." When asked if a nurse should ever hold Lantus, LPN #4 stated, "If there are parameters for it depends on what the order says." When asked if there are no parameters, can a nurse hold it, LPN #4 stated, "If there is a question, you can call the doctor and get an order." LPN #4 was asked to review the above physician order for Resident #93 and the MAR. When asked why she didn't give the insulin on those dates, LPN #4 stated, "It looks like it (the blood sugar) was under 100 and usually we have orders to hold for less than 100." When asked if she had an order to hold if less than 100, LPN #4 stated, "No, Ma'am." When asked what staff should do when they hold a medication, LPN # 4 stated, "We usually contact the doctor and the responsible party." LPN #4 was asked to review her nurse's notes for the above dates. When asked if she had documentation that she</p>	F 656			

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F 656	<p>Continued From page 66</p> <p>contacted the doctor and responsible party when she held the insulin, LPN #4 stated, "It's not there. I didn't do it." When asked the purpose of the comprehensive care plan, LPN #4 stated, "It' how to take care of the resident." When asked if the care plan should be followed, LPN #4 stated, "Yes."</p> <p>On 5/2/19 at 10:01 a.m., an interview was conducted with LPN #5, (one of the nurse's that held the above ordered insulin). When asked what Lantus is, LPN #5 stated, "Insulin." When asked if it's long acting or short acting insulin, LPN #5 stated, "I believe it's long acting." When asked if a nurse should hold Lantus, LPN #5 stated, "If there are specific parameters on the orders we are supposed to." LPN #5 reviewed the above physician orders for Resident #93, MAR and nurse's notes. When asked if the physician ordered specific parameters for this resident, LPN #5 stated, "No." LPN #5 verified her initials on the MAR. When asked why the insulin was held, LPN #5 stated, "Because his blood sugar was low. I shouldn't have done that. I should have called the doctor. That is my error." When asked if she called the doctor, LPN #5 stated, "No." When asked the purpose of the care plan, LPN #5 stated, "It's to tell you how to take care of the patient." When asked if staff should implement/follow the care plan, LPN #5 stated, "Yes."</p> <p>The facility policy, "Interdisciplinary Care Planning" documented in part, "CARE PLANNING - The patient's care plan is a communication tool that guides members of the interdisciplinary healthcare team in how to meet each individual patient's needs. It also identifies the types and methods of care that the patient</p>	F 656			

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F 656	<p>Continued From page 67</p> <p>should receive...Once the care plan is developed, the staff must implement the interventions identified in the care plan. These may include, but is not limited to: administering treatments and medications, performing therapies and participating in activities with the patient."</p> <p>According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders...</p> <p>ASM (administrative staff member) #2, the mobile administrator, ASM #1, the interim administration, and ASM #3, the assisted living facility executive director, were made aware of the above concern on 5/2/19 at 10.58 a.m.</p> <p>No further information was provided prior to exit.</p> <p>(1) This information was obtained from the following website: <a href="https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html">https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html</a>.</p> <p>(2) This information was obtained from the following website: <a href="https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100">https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100</a>.</p> <p>2. The facility staff failed to implement the</p>	F 656			

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F 656	<p>Continued From page 68</p> <p>comprehensive care plan for the administration of insulin (1) for Resident # 26.</p> <p>Resident # 26 was admitted to the facility on 11/22/2016 with diagnoses that included but were not limited to dementia (2), depressive disorder (3), dysphagia (4) and diabetes mellitus (5).</p> <p>Resident # 26's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/08/19, coded Resident # 26 as scoring a 9 (nine) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 9 (nine)-being moderately impaired of cognition intact for making daily decisions. Resident # 26 was coded as requiring limited assistance of one staff member for activities of daily living.</p> <p>The physician's order sheet (POS) dated February, March, April 2019 for Resident # 26 documented "Novolog (6). Inject 5 units subcutaneously before meals for DM (diabetes mellitus). Hold for BS (blood sugar) &lt; (less than) 150. Order Date: 11/20/2018."</p> <p>The eMAR (electronic medication administration record) dated February 2019 for Resident # 26 documented the above physician's order for Novolog insulin. Further review of the eMAR revealed Novolog was administered on the following dates when the resident's blood sugar was below 150: 02/01/19 with blood sugar of 98, 02/02/19 with blood sugar of 68, 02/05/19 with blood sugar of 129, 02/08/19 with blood sugar of 127, 02/09/19 with blood sugar of 113, 02/11/19 with blood sugar of 85,</p>	F 656			

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F 656	<p>Continued From page 69</p> <p>02/16/19 with blood sugar of 97, 02/20/19 with blood sugar of 103 and 02/25/19 with blood sugar of 104.</p> <p>The eMAR (electronic medication administration record) dated March 2019 for Resident # 26 documented the above physician's order for Novolog insulin. Further review of the eMAR revealed Novolog was administered when the resident's blood sugar was below 150: On 03/02/19 with blood sugar of 114, 03/03/19 with blood sugar of 93 and 103, 03/05/19 with blood sugar of 136, 03/10/19 with blood sugar of 104, 03/11/19 with blood sugar of 120 and 88, 03/16/19 with blood sugar of 97, 03/17/19 with blood sugar of 91, 03/19/10 with blood sugar of 135, 03/21/19 with blood sugar of 130, 03/25/19 with blood sugar of 11 and 144, 03/29/19 with blood sugar of 140, 03/30/19 with blood sugar of 92 and 03/31/19 with blood sugar of 137.</p> <p>The eMAR (electronic medication administration record) dated April 2019 for Resident # 26 documented the above physicians order for Novolog insulin. Further review of the eMAR revealed Novolog was administered on the following dates when the resident's blood sugar was below 150: 04/05/19 with blood sugar of 112, 04/08/19 with blood sugar of 114, 04/10/19 with blood sugar of 119, 04/12/19 with blood sugar of 98, 04/13/19 with blood sugar of 101, 04/16/19 with blood sugar of 129 and 102, 04/21/19 with blood sugar of 101 and 144, 04/22/19 with blood sugar of 95,</p>	F 656			

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F 656	<p>Continued From page 70</p> <p>04/27/19 with blood sugar of 72, 04/29 with blood sugar of 134 and 04/30/19 with blood sugar of 109.</p> <p>The comprehensive care plan for Resident # 12 dated 11/23/2016 documented, "Focus. Endocrine System related to; insulin Dependent Diabetes." Under "Interventions" it documented, "Administer medication per physician orders. Date Initiated 11/23/2016."</p> <p>On 05/02/19 at 12:38 p.m., an interview was conducted with RN (registered nurse) # 6, unit manager. When asked to describe the check marks on the eMARs, RN # 6 stated, "It means it (insulin) was given." After reviewing Resident # 26's physician's order sheets dated February, March and April 2019 and the eMARS dated February, March and April where the insulin was administered with blood sugars below 150 and the comprehensive care plan, RN # 6 stated, "The care plan gives us a full view of the resident and goals we have for the resident's comprehensive care. Care plan is not being followed for the administration of insulin."</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (administrative staff member) # 1, the interim administrator and ASM # 2, mobile administrator, ASM # 3, executive director of the assisted living facility, and ASM # 4, director of nursing were made aware of the findings.</p> <p>No further information was provided prior to exit.</p> <p>References: (1) With type 1 diabetes, your pancreas does not make insulin. Insulin is a hormone that helps glucose get into your cells to give them energy.</p>	F 656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/02/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
(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 656	<p>Continued From page 71</p> <p>Without insulin, too much glucose stays in your blood. If you have type 1 diabetes, you will need to take insulin. Type 2 diabetes, the most common type, can start when the body doesn't use insulin as it should. If your body can't keep up with the need for insulin, you may need to take pills. Along with meal planning and physical activity, diabetes pills help people with type 2 diabetes or gestational diabetes keep their blood glucose levels on target. Several kinds of pills are available. Each works in a different way. Many people take two or three kinds of pills. Some people take combination pills. Combination pills contain two kinds of diabetes medicine in one tablet. Some people take pills and insulin. This information was obtained from the website: <a href="https://medlineplus.gov/diabetesmedicines.html">https://medlineplus.gov/diabetesmedicines.html</a>.</p> <p>(2) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/000739.htm">https://medlineplus.gov/ency/article/000739.htm</a>.</p> <p>(3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/003213.htm">https://medlineplus.gov/ency/article/003213.htm</a>.</p> <p>(4) A swallowing disorder. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html">https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html</a>.</p>	F 656			



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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
(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 656	<p>Continued From page 72</p> <p>(5) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm">https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm</a>.</p> <p>(6) A rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. This information was obtained from the website: <a href="https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5">https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5</a>.</p> <p>3. The facility staff failed to implement the comprehensive care plan for the administration of insulin (1) for Resident # 12.</p> <p>Resident # 12 was admitted to the facility on 01/21/2019 with diagnoses that included but were not limited to malignant neoplasm of lung (2), depressive disorder (3), diabetes mellitus (4) gastroesophageal reflux disease (5), and convulsions (6).</p> <p>Resident # 12s most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/28/19, coded Resident # 12 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions. Resident # 12 was coded as being independent and not requiring set up by staff members for activities of daily living.</p> <p>The physician's order sheet (POS) dated February 2019 for Resident # 12 documented "Novolin (6) (Insulin). Inject 5 units</p>	F 656			

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
(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 656	<p>Continued From page 73</p> <p>subcutaneously (7) two times a day for diabetes. May hold if blood sugar is less than 100. Order Date: 02/13/2019."</p> <p>The physician's order sheet (POS) dated April 2019 for Resident #12 documented, "Novolin (Insulin). Inject 5 units subcutaneously two times a day for DM (diabetes mellitus) give before breakfast and dinner. May hold if blood sugar is less than 100. Order Date: 03/26/2019."</p> <p>The eMAR (electronic medication administration record) dated February 2019 for Resident # 12 documented the above order for Novolin (Insulin). Further review of the eMAR revealed Novolin was administered on 02/15/19 with blood sugar of 75, on 02/16/19 with blood sugar of 91, 02/20/19 with blood sugar of 85, 02/27/19 with blood sugar of 94 and 77 and on 02/28/19 with blood sugar of 84.</p> <p>The eMAR (electronic medication administration record) dated April 2019 for Resident # 12 documented the above physician's order for Novolin (Insulin). Further review of the eMAR revealed Novolin was administered on 04/16/19 with blood sugar of 91, 04/29/19 with blood sugar of 96 and on 04/30/19 with blood sugar of 69.</p> <p>The comprehensive care plan for Resident # 12 dated 01/21/2019 documented, "Focus. Endocrine System related to; insulin Dependent Diabetes." Under "Interventions" it documented, "Administer medication per physician orders. Date Initiated 01/21/2019."</p> <p>On 05/02/19 at 12:38 p.m., an interview was conducted with RN (registered nurse) # 6, unit manager. When asked to describe the check</p>	F 656			

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
(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 656	<p>Continued From page 74</p> <p>marks on the eMARS, RN # 6 stated, "It means it (insulin) was given." After reviewing Resident # 12's physician's order sheets dated February and April 2019, the eMARS dated February and April where the insulin was administered with blood sugars below 100 and the comprehensive care plan, RN # 6 stated, "The care plan gives us a full view of the resident and goals we have for the resident's comprehensive care. Care plan is not being followed for the administration of insulin."</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (administrative staff member) # 1, the interim administrator and ASM # 2, mobile administrator, ASM # 3, executive director of the assisted living facility, and ASM # 4, director of nursing were made aware of the findings.</p> <p>No further information was provided prior to exit.</p> <p>References: (1) With type 1 diabetes, your pancreas does not make insulin. Insulin is a hormone that helps glucose get into your cells to give them energy. Without insulin, too much glucose stays in your blood. If you have type 1 diabetes, you will need to take insulin. Type 2 diabetes, the most common type, can start when the body doesn't use insulin as it should. If your body can't keep up with the need for insulin, you may need to take pills. Along with meal planning and physical activity, diabetes pills help people with type 2 diabetes or gestational diabetes keep their blood glucose levels on target. Several kinds of pills are available. Each works in a different way. Many people take two or three kinds of pills. Some people take combination pills. Combination pills contain two kinds of diabetes medicine in one tablet. Some people take pills and insulin. This</p>	F 656			

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
(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 656	<p>Continued From page 75</p> <p>information was obtained from the website: <a href="https://medlineplus.gov/diabetesmedicines.html">https://medlineplus.gov/diabetesmedicines.html</a>.</p> <p>(2) Lung cancer is cancer that starts in the lungs. The lungs are located in the chest. When you breathe, air goes through your nose, down your windpipe (trachea), and into the lungs, where it flows through tubes called bronchi. Most lung cancer begins in the cells that line these tubes. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/007270.htm">https://medlineplus.gov/ency/article/007270.htm</a>.</p> <p>(3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/003213.htm">https://medlineplus.gov/ency/article/003213.htm</a>.</p> <p>(4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm">https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm</a>.</p> <p>(5) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/gerd.html">https://www.nlm.nih.gov/medlineplus/gerd.html</a>.</p> <p>(6) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website:</p>	F 656			

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
(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 656	<p>Continued From page 76 <a href="https://medlineplus.gov/ency/article/003200.htm">https://medlineplus.gov/ency/article/003200.htm</a>.</p> <p>(7) Is indicated to improve glycemic control in adults and pediatric patients with diabetes mellitus. This information was obtained from the website: <a href="https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=82f1445c-b2c6-445a-82cf-ba8825fac776">https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=82f1445c-b2c6-445a-82cf-ba8825fac776</a></p> <p>(8) The term "cutaneous" refers to the skin. Subcutaneous means beneath, or under, all the layers of the skin. For example, a subcutaneous cyst is under the skin. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/002297.htm">https://medlineplus.gov/ency/article/002297.htm</a>.</p> <p>4. The facility staff failed to implement Resident #17's comprehensive care plan for the administration of diabetic medications.</p> <p>Resident #17 was admitted to the facility on 7/27/18, with the diagnoses that included, but not limited to, diabetes, high blood pressure, atrial fibrillation, dementia with behaviors, depression, and anxiety disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/1/19. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; supervision for transfers, ambulation, dressing, toileting and hygiene; was independent for eating, and was continent of bowel and bladder.</p> <p>A review of the clinical record revealed the following physician orders that were in effect for</p>	F 656			

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 656	<p>Continued From page 77</p> <p>all or part of February 2019: An order dated 9/4/18 for Lantus (1) 40 units at bedtime. This order was discontinued on 4/18/19. An order dated 2/13/19 for Novolog (2) Flexpen 3 units before meals, hold if blood sugar is below 100. This order was discontinued on 2/27/19.</p> <p>A review of the February 2019 MAR revealed the following: On 2/14/19 - the morning dose of Novolog 3 units was given. The medication was to be held if the blood sugar was less than 100. The resident's blood sugar was 79. There was no evidence of physician notification that the medication was given when the blood sugar was outside of parameters to give the medication. On 2/15/19 - the morning dose of Novolog 3 units was given. The medication was to be held if the blood sugar was less than 100. The resident's blood sugar was 89. There was no evidence of physician notification that the medication was given when the blood sugar was outside of parameters to give the medication.</p> <p>On 2/19/19 - no evidence of the Lantus 40 units being administered at bedtime. The MAR was left blank. On 2/25/19 - the morning dose of Novolog 3 units was given. The medication was to be held if the blood sugar was less than 100. The resident's blood sugar was 95. There was no evidence of physician notification that the medication was given when the blood sugar was outside of parameters to give the medication.</p> <p>A review of the clinical record revealed the following physician orders that were in effect for all or part of March 2019: An order dated 9/4/18 for Lantus 40 units at bedtime. This order was</p>	F 656			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/02/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
(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 656	<p>Continued From page 78</p> <p>discontinued on 4/18/19. An order dated 2/27/19 for Humalog (3) 6 units before meals. This order was discontinued on 3/5/19. An order dated 3/5/19 for Novolog 6 units before meals. This order remained active as of the survey.</p> <p>A review of the March 2019 MAR revealed the following: On 3/4/19 - lunchtime dose of Humalog 6 units was held. There were no orders or parameters to hold the Humalog. The resident's blood sugar was 92. There was no evidence the physician was notified of the Humalog being held when it was not ordered to be held. On 3/6/19 - the morning Novolog of 6 units was held. There were no orders or parameters to hold the Novolog. The resident's blood sugar was 83. There was no evidence the physician was notified of the Novolog being held when it was not ordered to be held. On 3/10/19 - the morning Novolog of 6 units was held. There were no orders or parameters to hold the Novolog. The resident's blood sugar was 95. There was no evidence the physician was notified of the Novolog being held when it was not ordered to be held. On 3/10/19 - no evidence of the Lantus 40 units being administered at bedtime. The MAR was left blank. On 3/15/19 - the morning Novolog of 6 units was held. There were no orders or parameters to hold the Novolog. The MAR was coded as "Other/See Nurse Notes." The notes documented the blood sugar was 79. There was no evidence the physician was notified of the Novolog being held when it was not ordered to be held. On 3/17/19 - no evidence of the Lantus 40 units being administered at bedtime. The MAR was left blank. On 3/27/19 - no evidence of the Lantus 40 units being administered at bedtime. The MAR was coded as "Other/See Nurse</p>	F 656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/02/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
(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 656	<p>Continued From page 79</p> <p>Notes." The notes documented the blood sugar was 72 and rechecked to be 80. There were no orders to hold the Lantus. There was no evidence the physician or nurse practitioner was notified of the medication being held.</p> <p>A review of the clinical record revealed the following physician orders that were in effect for all or part of March 2019: An order dated 9/4/18 for Lantus 40 units at bedtime. This order was discontinued on 4/18/19. An order dated 3/5/19 for Novolog 6 units before meals. This order remained active as of the survey.</p> <p>A review of the April 2019 MAR revealed the following: On 4/2/19 - no evidence of the lunchtime Novolog 6 units being administered. The MAR was left blank. On 4/3/19 - no evidence of the Lantus 40 units being administered at bedtime. The MAR was left blank. On 4/3/19 - the morning dose of Novolog 6 units was held. The blood sugar was 117. There were no orders or parameters to hold the Novolog. There was no evidence the physician was notified of the Novolog being held when it was not ordered to be held. On 4/3/19 - the lunchtime dose of Novolog 6 units was held. There was no documented blood sugar. There were no orders or parameters to hold the Novolog. There was no evidence the physician was notified of the Novolog being held when it was not ordered to be held. On 4/11/19 - the lunchtime dose of Novolog 6 units was held. The blood sugar was 99. There were no orders or parameters to hold the Novolog. There was no evidence the physician was notified of the Novolog being held when it was not ordered to be held.</p>	F 656			



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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
(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 656	Continued From page 80  A review of the care plan revealed one dated 7/27/18 for "Endocrine System related to; Insulin Dependent Diabetes." This care plan included the interventions, "Administer medication per physician orders" dated 7/27/18, "Obtain glucometer readings and report abnormalities as ordered" dated 2/12/19, "Obtain Lab results as ordered and notify physician of results" dated 7/27/18.  On 5/2/19 at 11:06 AM, an interview was conducted with LPN #1. When informed about the above findings of insulins held when there was no parameters or orders to hold the insulin. LPN #1 was informed about the insulins being administered when there were ordered parameters to hold it, and informed of insulins not being documented at all as being administered when they should be. When asked if the care plan documented to administer insulin as ordered, and the above errors were made regarding the administration of insulin, was the care plan followed, LPN #1 stated it was not.  On 5/2/19 at 11:20 AM, ASM #1 (Administrative Staff Member) (Administrator), ASM #2 (Mobile Administrator), ASM #3 (ALF Executive Director) and ASM #4 (Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey.  (1) Lantus - Insulin glargine is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the	F 656			

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 656	<p>Continued From page 81</p> <p>amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes. In people with type 1 diabetes, insulin glargine must be used with another type of insulin (a short-acting insulin). In people with type 2 diabetes, insulin glargine also may be used with another type of insulin or with oral medication(s) for diabetes. Insulin glargine is a long-acting, manmade version of human insulin. Insulin glargine works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar.</p> <p>Information obtained from <a href="https://medlineplus.gov/druginfo/meds/a600027.html">https://medlineplus.gov/druginfo/meds/a600027.html</a></p> <p>(2) Novolog - Insulin aspart is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. In patients with type 1 diabetes, insulin aspart is usually used with another type of insulin, unless it is used in an external insulin pump. In patients with type 2 diabetes, insulin aspart also may be used with another type of insulin or with oral medication(s) for diabetes. Insulin aspart is a short-acting, manmade version of human insulin. Insulin aspart works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body</p>	F 656			

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F 656	<p>Continued From page 82</p> <p>tissues where it is used for energy. It also stops the liver from producing more sugar. Information obtained from <a href="https://medlineplus.gov/druginfo/meds/a605013.html">https://medlineplus.gov/druginfo/meds/a605013.html</a></p> <p>(3) Humalog - Insulin lispro is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. In patients with type 1 diabetes, insulin lispro is always used with another type of insulin, unless it is used in an external insulin pump. In patients with type 2 diabetes, insulin lispro may be used with another type of insulin or with oral medication(s) for diabetes. Insulin lispro is a short-acting, manmade version of human insulin. Insulin lispro works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar. Information obtained from <a href="https://medlineplus.gov/druginfo/meds/a697021.html">https://medlineplus.gov/druginfo/meds/a697021.html</a></p> <p>5. The facility staff failed to develop a comprehensive care plan to address Resident #127's oxygen use.</p> <p>Resident #127 was admitted to the facility on 04/04/19, with diagnoses that included but were not limited to: hypertension (1), coronary artery diseases (CAD) (2), and dementia (3).</p>	F 656			

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F 656	<p>Continued From page 83</p> <p>The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 04/15/19, coded the resident as scoring a 7 on the BIMS (brief interview for mental status) score of 0-15, 7 indicating severe cognitive impairment for daily decision-making. The resident was coded as totally dependent upon two or more staff members for all of activities of daily living. In Section O- Special treatments and programs, the resident was coded C. oxygen therapy.</p> <p>On 04/30/19 at 2:36 p.m. and on 05/01/19 8:11 a.m., an observation of the resident's room revealed the resident was in bed receiving oxygen by nasal cannula connected to an oxygen concentrator. The oxygen concentrator flowmeter was observed set between one and one-and-half liter per minute.</p> <p>Review of Resident #127's electric clinical record on 05/01/19 failed to evidence a comprehensive care plan for the use of oxygen.</p> <p>The physician orders dated 04/05/19 documented, "O2 (oxygen) 2 (two) liters per minute via (by) nasal cannula (4) every shift for hypoxia."</p> <p>On 05/02/19 1:54 p.m., an interview was conducted with RN (registered nurse) #6, unit manager. When asked if residents receiving oxygen should have a comprehensive care plan to address the use of oxygen, RN #6 stated "Yes." When asked the purpose of the comprehensive care plan, RN #6 stated, "It is a tool that displays a comprehensive picture of a resident's needs and a resident's behavior. When asked who was responsible for developing</p>	F 656			

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F 656	<p>Continued From page 84</p> <p>the comprehensive care plan, RN #6 stated, "It is done by a collaboration of a multi-disciplinary team, but the oxygen care plan should have been done by the nursing staff." Resident #127's existing care plan was reviewed with RN #6 and she was asked if she could evidence a care plan for Resident #127's oxygen use. RN #6 stated, "I do not see one." RN #6 agreed that the resident did not have a care plan for the use of oxygen. When asked what policies and procedures the facility follows for the development of the care plan, RN #6 stated she would need to check.</p> <p>Review of the facility policy, "Interdisciplinary care planning" documented in part under comprehensive care planning requirements, "The facility must develop and implement a comprehensive person-center care plan for each patient that includes measurable objectives and timeframes to meet a patient's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment ...A comprehensive care plan must be developed within 7 (seven) days after completion of the comprehensive assessment."</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (Administrative Staff Member) #2, the mobile administrator, and ASM #4, the director of nursing, were made aware of the above findings.</p> <p>No further information was provided prior to exit</p> <p>References:</p> <p>1. High blood pressure. This information was obtained from the website:</p>	F 656			

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F 656	<p>Continued From page 85</p> <p><a href="https://www.nlm.nih.gov/medlineplus/highbloodpressure.html">https://www.nlm.nih.gov/medlineplus/highbloodpressure.html</a>.</p> <p>2. A common type of heart disease. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html">https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html</a></p> <p>3. A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/000739.htm">https://medlineplus.gov/ency/article/000739.htm</a>.</p> <p>4. Tubing used to deliver oxygen at levels from 1 to 6 L/min. The nasal prongs of the cannula extend approx. 1 cm into each naris and are connected to a common tube, which is then connected to the oxygen source. It is used to treat conditions in which a slightly enriched oxygen content is needed, such as emphysema. The exact percentage of oxygen delivered to the patient varies with respiratory rate and other factors. This information was obtained from the website: <a href="http://medical-dictionary.thefreedictionary.com/nasal+cannula">http://medical-dictionary.thefreedictionary.com/nasal+cannula</a>.</p> <p>6. The facility staff failed to implement Resident #72's comprehensive care plan for the administration of oxygen.</p> <p>Resident #72 was admitted to the facility on 12/28/11 and was readmitted on 3/5/19. Diagnoses included but were not limited to: atrial fibrillation (1), chronic obstructive pulmonary disease (COPD) (2), anemia and weakness.</p> <p>The most recent MDS (minimum data set), a</p>	F 656			

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F 656	<p>Continued From page 86</p> <p>Medicare fourteen day assessment, with an ARD (assessment reference date) of 3/17/19 coded the resident as having a score of 5 out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely cognitively impaired. Section O0100 documented Resident #72's oxygen use.</p> <p>The physician order dated 3/6/19 documented, "O2 (Oxygen) at 3 liters per minute via NC (nasal cannula) to maintain O2 saturation &gt; (greater then) 90%."</p> <p>Review of the MAR (medication administration record) for Resident #72 dated April 2019 documented, "O2 (Oxygen) at 3 liters per minute via NC (nasal cannula) to maintain O2 saturation &gt;90%." The oxygen was documented as administered per the physician order during the month of April.</p> <p>On 04/30/19 at approximately 1:44 p.m., an observation was made of Resident #72. Resident #72 was seated in her wheelchair wearing a nasal cannula attached to an oxygen concentrator. The oxygen concentrator flow rate was observed set between 2.5 and 3L/min (liters/min) of oxygen.</p> <p>On 04/30/19 at approximately 4:07 p.m., a second observation was made of Resident #72. Resident #72 was again wearing a nasal cannula that was attached to an oxygen concentrator. Resident #72's flow rate on the oxygen concentrator was again observed set between 2.5 and 3L/min oxygen.</p> <p>On 04/30/19 at approximately 04:09 p.m., a third observation was made of Resident #72 with LPN (licensed practical nurse) #6. Resident #72 was</p>	F 656			

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F 656	<p>Continued From page 87</p> <p>again wearing a nasal cannula that was attached to an oxygen concentrator. The oxygen concentrator flow rate was again observed set between 2.5 and 3L/min oxygen.</p> <p>The care plan dated 3/18/19 documented, "Administer oxygen as per physician order."</p> <p>On 05/01/19 at approximately 3:02 p.m., an interview was conducted with RN (register nurse) #5. When asked the purpose of a care plan, RN #5 stated, "It lets you know the plan of care for the resident." When asked if the care plan should be followed, RN #5 replied, "Yes." When asked is the care plan regarding Resident #72's oxygen was being followed. RN #5 replied, "No, that would be an error."</p> <p>The facility policy, "Interdisciplinary Care Planning" documented in part, "Once the care plan is developed, the staff must implement the interventions identified in the care plan."</p> <p>On 05/02/19 at approximately 1:00 p.m., ASM (administrative staff member) #1, the Interim Administrator, ASM #2, the Mobile Administrator and ASM #3, the Assisted Living Facility (ALF) Executive Director were made aware of the findings.</p> <p>No further information was provided prior to exit.</p> <p>1. Atrial fibrillation is one of the most common types of arrhythmias, which are irregular heart rhythms. Atrial fibrillation causes the heart to beat much faster than normal, and the upper and lower chambers of the heart do not work together. When this happens, the lower chambers do not fill completely or pump enough</p>	F 656			



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F 656	Continued From page 88 blood to the lungs and body. This can make you feel tired or dizzy, or you may notice heart palpitations or chest pain. Blood also pools in the heart, which increases your risk of having a stroke or other complications. This information was obtained from the website: <a href="https://www.nhlbi.nih.gov/health-topics/atrial-fibrillation">https://www.nhlbi.nih.gov/health-topics/atrial-fibrillation</a>	F 656			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		5/23/19	

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F 657	<p>Continued From page 89</p> <p>and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to review or revise the care plan for two of 56 residents in the survey sample, Resident # 18 and # 39.</p> <p>1. The facility staff failed to update Resident # 89's comprehensive care with current diversionary interventions to alleviate Resident # 89's pain.</p> <p>2. The facility staff failed to review and revise the comprehensive care plan to address Resident #18's AICD (automatic internal cardiac device).</p> <p>The findings include:</p> <p>1. The facility staff failed to update Resident # 89's comprehensive care with current diversionary interventions to alleviate Resident # 89's pain.</p> <p>Resident # 89 was admitted to the facility on 08/16/2018 with diagnoses that included but were not limited to benign prostatic hyperplasia (1), Parkinson's disease (2), and hypertension (3).</p>	F 657	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p style="text-align: center;">F-657</p> <p>It is the intended practice of this facility to review and/or revise the care plans of each resident after each assessment.</p> <p>1. Resident #18 care plan was revised on May 8, 2019 to reflect the care of AICD. Resident #89 care plan was revised on May 20, 2019 to reflect diversional and non-pharmacological intervention for pain management.</p> <p>2. Residents that reside in the facility</p>		

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F 657	<p>Continued From page 90</p> <p>Resident # 89's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/29/2019, coded Resident # 89 as scoring a 3 (three) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions. Resident # 89 was coded as requiring extensive assistance of one staff member for activities of daily living. Section O "Special Treatments, Procedures and Programs" coded Resident # 89 as "K. Hospice Care."</p> <p>The POS (physician's order sheet) dated 03/31/2019 for Resident # 89 documented, "Admit to (Name of Hospice). Order Date: 03/18/2019."</p> <p>The comprehensive care plan for Resident # 89 documented, "Focus: Pain evidenced by verbalization of pain related to knee pain/osteoarthritis. Date Initiated: 08/17/2018." Under "Interventions" it documented, "Report GI (gastro-intestinal) distress secondary to analgesia such [sic] nausea, constipation, diarrhea. Date Initiated: 08/17/2018; Report nonverbal expressions of pain as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc. Date Initiated: 08/17/2018: Administer pain medication per physician order. Date Initiated: 08/17/2019, Encourage/assist to reposition frequently to position of comfort. Date Initiated: 08/17/2018, Notify physician if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective. Date Initiated: 08/17/2018."</p> <p>On 05/02/19 at 11:56 a.m., an interview was conducted with RN # 6 regarding the continuity of</p>	F 657	<p>have the potential to be affected.</p> <p>3. Licensed Nurses and the Interdisciplinary Team (IDT) were educated on the care plan timing and revision.</p> <p>4. Director of Nursing and/or designee will audit care plans for newly admitted residents in regards to diversional activities related to pain management and newly admitted residents for AICD. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated.</p> <p>5. The facility alleged date of compliance is June 11, 2019.</p>		

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F 657	<p>Continued From page 91</p> <p>care and collaboration of Resident # 89's hospice care. After reviewing Resident # 89's comprehensive care plan, RN #6 was asked if the care plan identified non-pharmacological interventions to address Resident # 89's pain. RN # 6 stated, "Yes, to reposition frequently to position of comfort." When asked if that was the only intervention that was being used by staff to address Resident # 89's pain, RN # 6 stated, "He also has a stuffed dog that he likes that provides comfort for him and he likes watching others so we bring him out to the nurse's station. These are diversionary activities." When asked if these interventions should be a part of the comprehensive care plan for Resident # 89, RN # 6 stated, "Yes." When asked if his care plan is comprehensive for pain, RN # 6 stated, "No."</p> <p>The facility's policy "Interdisciplinary Care Planning" documented, "Care Planning: The patient's care plan is a comprehensive tool that guides members of the interdisciplinary healthcare team in how to meet each individual patient's needs. It also identifies the types and methods of care that the patient should receive." Under "Care Plan Components" it documented, "Interventions identify specific, individualized elements of care, provided by staff which will help patients achieve their goals. Interventions and the instructions for delivering patient care and allow for continuity of care by staff. Just like goals, interventions are specific and measurable." Under "Comprehensive Care Planning Requirements" it documented, "A comprehensive care plan must be - Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive, quarterly and significant change review assessments."</p>	F 657			

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 657	<p>Continued From page 92</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (administrative staff member) # 1, the interim administrator and ASM # 2, mobile administrator, ASM # 3, executive director of the assisted living facility, and ASM # 4, director of nursing were made aware of the findings.</p> <p>No further information was provided prior to exit.</p> <p>References:</p> <p>(1) An enlarged prostate. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html">https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html</a>.</p> <p>(2) High blood pressure. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/highbloodpressure.html">https://www.nlm.nih.gov/medlineplus/highbloodpressure.html</a>.</p> <p>2. The facility staff failed to review and revise the comprehensive care plan to address the resident's AICD (automatic internal cardiac device) for Resident #18.</p> <p>Resident #18 was admitted to the facility on 10/21/15 with diagnoses that included but were not limited to: peripheral vascular disease [any abnormal condition, including atherosclerosis, affecting blood vessels outside the heart (1)], depression, amputation of left leg, high blood pressure, cardiac arrhythmias [An arrhythmia is a problem with the rate or rhythm of your heartbeat. It means that your heart beats too quickly, too slowly, or with an irregular pattern (2)], heart disease [There are many different forms of heart disease. The most common cause of heart disease is narrowing or blockage of the coronary arteries, the blood vessels that supply blood to</p>	F 657			

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F 657	<p>Continued From page 93</p> <p>the heart itself. This is called coronary artery disease and happens slowly over time. It's the major reason people have heart attacks (3)], atrial fibrillation [a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (4)] and the presence of automatic implantable cardiac defibrillator [Defibrillators are devices that restore a normal heartbeat by sending an electric pulse or shock to the heart. They are used to prevent or correct an arrhythmia, a heartbeat that is uneven or that is too slow or too fast. Defibrillators can also restore the heart's beating if the heart suddenly stops. Other defibrillators can prevent sudden death among people who have a high risk of a life-threatening arrhythmia. They include implantable cardioverter defibrillators (ICDs), which are surgically placed inside your body (5)].</p> <p>The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 2/1/18, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. Resident #18 was coded as anywhere from being independent to requiring extensive assistance of one staff member for his activities of daily living. In Section I - Active Diagnoses, it was documented the resident had the presence of automatic (implantable) cardiac defibrillator.</p> <p>Observation was made of Resident #18 on 5/1/19 at 8:42 a.m. He was sitting in his wheelchair in the doorway, with no shirt on. Further observation revealed what appeared to be, a pacemaker in his left upper chest. When asked what type of</p>	F 657			

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F 657	<p>Continued From page 94</p> <p>device the resident had, he stated he had no knowledge of it.</p> <p>The comprehensive care plan dated, 12/2/15 and revised on 2/27/19, documented in part, "Focus: Cardiac disease related to Hx (history) of MI (myocardial infarction - heart attack), CAD (coronary artery disease), HTN (high blood pressure) and Hx of atrial flutter, angina." The "Interventions" documented in part, "Pacemaker (FYI [for your information])."</p> <p>Review of the clinical record revealed documented on the face sheet, "Presence of automatic (Implantable) cardiac defibrillator."</p> <p>Review of the physician orders failed to reveal anything related to an implantable device in the resident's chest.</p> <p>On 5/1/19 at 1:45 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the nurse that cares for Resident #18. When asked what type of device Resident #18 has in his chest, LPN #4 stated, "It's a pacemaker." When asked if the nursing staff have anything to do with it, LPN #4 stated, "He has an annual cardiology appointment that his sister sets and takes him to. There's a box in his room and we check to make sure it's working." LPN #4 and this surveyor went to the resident's room. There on the resident's nightstand was a machine. LPN #4 stated, "We just check to ensure the machine is on unless they call to hook him up." When asked how often they are checking it, LPN #4 stated she'd have to check the chart. LPN #4 and this surveyor went back to the nurse's station. RN (registered nurse) #2, a unit manager, joined LPN #4. When RN #2 was asked what device the</p>	F 657			

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F 657	<p>Continued From page 95</p> <p>resident has implanted in his chest, how often staff are checking it, and where staff document checking the box, and should there be an order, RN #2 stated, "Yes, if we don't have an order, this is the situation we get into. When asked if the type of device and the care needed should be on the care plan, RN #2 stated, "Yes." When asked when Resident #18 last had a cardiology appointment, RN #2 and LPN #4 stated they would need to check.</p> <p>On 5/1/19 at 3:45 p.m. (two hours after the initial conversation with LPN #4 and RN #2) RN #2 was asked if there was any information to present related to the device for Resident #18, RN #2 stated, "They were working on it."</p> <p>On 5/1/19 at 4:38 p.m., RN #2 returned and stated the cardiology notes document the resident has an AICD (automatic internal cardiac defibrillator) dual chamber device (it is both a defibrillator and pacemaker) that was placed in 2016. The family schedules his appointments and transports him to the appointment. His next scheduled appointment is 5/15/19. His last appointment was 1/23/19. RN #2 stated that he was due for his annual checkup. When asked if the clinical record should be correct and informed that the record indicates a pacemaker but was missing the defibrillator part, RN #2 stated, "Yes, it should be correct." When asked what the staff should be doing to care for the device, RN #2 stated, "monitoring his heart rate and blood pressure. Monitor for shortness of breath." When asked about the machine in the room, and what nursing staff should be doing, RN #2 stated, "We need to ensure its functioning." When asked how the staff does that, RN #2 stated, "We need to monitor it every day to ensure its functioning."</p>	F 657			



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

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F 657	<p>Continued From page 96</p> <p>When asked where that is documented, RN #2 stated, "I will have to find that out." When asked if the care plan should reflect that, he has an implanted combination device, RN #2 stated, "Yes." When asked if the care plan needs to be updated to reflect they type of implanted device and care that needs to be provided for Resident #18's AICD, RN #2 stated, "Yes, Ma'am."</p> <p>On 5/2/19 at 11:17 a.m., LPN #4 returned to this surveyor and stated the following, "The cardiologist called and told us we didn't have to do anything with the machine in the resident's room. It's done automatically. They (the cardiology office) calls the resident on his phone and he pushes a button. If there were a malfunction, they would call the nursing home.</p> <p>On 5/2/19 at approximately 11:30 a.m., RN #2 presented a letter dated, 5/2/19, from the cardiologist. The letter documented in part, "(Resident #18) has a dual chamber ICD implanted. He is on the following device check schedule - every 3 months a remote check (this is when he checks the device at his residence) and a yearly office device check. According to his chart, his last remote device check was 2/27/19 and his last office device check was 7/25/17. His next scheduled remote check is 5/15/19 and his next appointment with (name of cardiologist) is 5/29/19 and at that time his ICD will be checked in office." When asked if the facility should have had this information and care planned this information before the surveyor questioned it, RN #2 stated, "Yes, Ma'am."</p> <p>Monitoring - People with ICDs require monitoring throughout their lifetime, generally every three to six months. The device can be painlessly</p>	F 657			

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F 657	<p>Continued From page 97</p> <p>examined with a specialized computer programmer that is placed on the area of the chest where the ICD is located. ICD manufacturers have developed technology to allow patients to have this evaluation from their home using the internet or over the telephone. This is called home or remote monitoring. Information stored on the device can be reviewed to determine the remaining battery life, lead stability and function, programmed settings, assess pacing and shocks provided, and obtain data concerning the type of rhythm disturbances treated. Home monitoring systems are not continuously monitoring the ICD. Typically, the device is checked every night and alerts are sent to the patient's provider if they meet certain criteria for alarm. For example, if the battery prematurely is depleted, then an alert will be sent to the patient's device clinic where these alerts are looked for routinely during business hours. If a patient has symptoms, they should be contacting their physician or nurse in the device clinic. (6)</p> <p>ASM (administrative staff member) #2, the mobile administrator, ASM #1, the interim administration, and ASM #3, the assisted living facility executive director, were made aware of the above concern on 5/2/19 at 10.58 a.m.</p> <p>No further information was obtained prior to exit.</p> <p>(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447.</p> <p>(2) This information was obtained from the following website: <a href="https://medlineplus.gov/arrhythmia.html">https://medlineplus.gov/arrhythmia.html</a>.</p>	F 657			

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F 657	Continued From page 98  (3) This information was obtained from the following website: <a href="https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&amp;v%3Asources=medlineplus-bundle&amp;query=Heart+disease">https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&amp;v%3Asources=medlineplus-bundle&amp;query=Heart+disease</a>  (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.  (5) This information was obtained from the following website: <a href="https://www.nhlbi.nih.gov/health-topics/defibrillators">https://www.nhlbi.nih.gov/health-topics/defibrillators</a> .  (6) This information was obtained from the following website: <a href="https://www.uptodate.com/contents/implantable-cardioverter-defibrillators-beyond-the-basics?search=implantable-cardioverter-defibrillators-beyond%20the%20basics&amp;topicRef=15665&amp;source=related_link">https://www.uptodate.com/contents/implantable-cardioverter-defibrillators-beyond-the-basics?search=implantable-cardioverter-defibrillators-beyond%20the%20basics&amp;topicRef=15665&amp;source=related_link</a> .	F 657			
F 658 SS=D	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 documentation in the clinical record and the	F 658	The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and	5/23/19	

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F 658	<p>Continued From page 99</p> <p>administartion of medications for two of 56 residents in the survey sample, Resident #93 and Resident #12.</p> <p>1. On 5/1/19, the facility staff documented Resident #93's "Acute Transfer Document Checklist" dated, 3/18/19, without indicating the date the documentation was completed on the form or that the documentation made was a late entry.</p> <p>2. The facility staff failed to clarify Resident # 12's physician ordered parameters for Novolog insulin to determine when and if the insulin should be held based on the residents blood sugar of 100.</p> <p>The findings include:</p> <p>Resident #93 was admitted to the facility on 8/18/17 with a recent readmission on 3/27/18, with diagnoses that included but were not limited to: dementia, psychosis [major mental disorder in which the person is usually detached from reality and has impaired perceptions, thinking, responses and interpersonal relationships (1)], diabetes and high blood pressure.</p> <p>The most recent MDS (minimum data set) assessment with an assessment reference date of 4/3/19, coded the resident as scoring a "1" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance for most of his activities of daily living. In Section N - Medications, the resident was coded as receiving five days of insulin injections during the look back period.</p>	F 658	<p>state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p style="text-align: center;">F-658</p> <p>It is the intended practice of the facility to follow Professional Standards of Practice for Documentation in the Clinical Record and administration of medication.</p> <p>1. Resident #93 had late entry on the Acute Care Transfer Documentation checklist placed on May 21, 2019. Resident #12 had clarification of insulin order completed on May 17, 2019.</p> <p>2. Residents who receive insulin and residents who are acutely transferred to the hospital and reside in the facility have the potential to be affected.</p> <p>3. Licensed Nurses and the Interdisciplinary Team (IDT) were re-educated on the Professional Standards of Practice for Documentation in the Clinical Record.</p> <p>4. Director of Nursing and/or designee will audit residents with acute care transfers for late entry documentation and residents with new insulin orders daily x 5 days and then 3 days a week x 3 weeks and the monthly x 2 months. The results of the random audits will be reported to</p>		

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F 658	<p>Continued From page 100</p> <p>A review of the clinical record was completed on 5/1/19. A document, "Acute Transfer Document Checklist" dated, 3/18/19, documented check marks next to the following items: Resident Transfer form, face sheet, current medication list of current MAR (medication administration record), and Relevant Lab (laboratory) Results (from the last 1 -3 months). There were no check marks next to Advanced Directives, Bed Hold Policy, Current Care Plan, Notification of transfer. A copy of the above document was requested on 5/1/19 at approximately 5:00 p.m. to ASM (administrative staff member) #2, the mobile administrator.</p> <p>The copy of this document was received on 5/2/19 at 8:30 a.m. from ASM #2. Upon review of this document, it was noted the document had been altered. Check marks now appeared next to: Advanced Directives, Bed Hold Policy, Current Care Plan, Notification of transfer.</p> <p>On 5/2/19 at 10:58 a.m. ASM #2, ASM #1, the interim administrator, and ASM #3, the assisted living facility executive director, were made aware of the concern of the altered document. ASM #2 stated she would have the director of nursing look into this and get back to this surveyor.</p> <p>On 5/2/19 at 12:03 p.m., an interview was conducted with ASM # 4, the director of nursing. ASM #4 informed this surveyor that on the previous night a unit manager was preparing the copies for the survey team and when she noticed the check marks not being there she questioned the nurse who sent the resident to the hospital on 3/18/19, if she had sent the unchecked items with the resident. The nurse that sent the resident to</p>	F 658	<p>the QAA Committee for review and follow up recommendations as indicated.</p> <p>5. The facility alleged date of compliance is June 11, 2019.</p>		

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F 658	<p>Continued From page 101</p> <p>the hospital went ahead, checked the boxes, and failed to initial or date the late entry. When asked what should have been done, ASM #4 stated, "It could have been checked with a date and initials or a late entry could have been made in the clinical record."</p> <p>The facility policy, "Requirements and Guidelines for Clinical Record Content" failed to evidence anything related to late entries in the clinical record or falsification of a record.</p> <p>The following quotation is found in Lippincott's Fundamentals of Nursing 5th edition (2007, page 237): "The client record serves as a legal document of the client's health status and care received ...Because nurses and other healthcare team members cannot remember specific assessments or interventions involving a client years after the fact, accurate and complete documentation at the time of care is essential. The care may have been excellent, but the documentation must prove it."</p> <p>Lippincott Manual of Nursing Practice 10th Edition page 16 "Standards of Practice General Principles. 5. A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events."</p> <p>ASM (administrative staff member) #2, the mobile administrator, ASM #1, the interim administration, and ASM #3, the assisted living facility executive director, were made aware of the above concern</p>	F 658			

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 658	<p>Continued From page 102 on 5/2/19 at 10.58 a.m.</p> <p>No further information was provided prior to exit.</p> <p>(1) This information was obtained from the following website: <a href="https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html">https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html</a>.</p> <p>2. The facility staff failed to clarify Resident # 12's physician ordered parameters for Novolog insulin to determine when and if the insulin should be held based on the residents blood sugar of 100.</p> <p>Resident # 12 was admitted to the facility on 01/21/2019 with diagnoses that included but were not limited to malignant neoplasm of lung (3), depressive disorder (4), diabetes mellitus (5) gastroesophageal reflux disease (6), and convulsions (7).</p> <p>Resident # 12's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/28/19, coded Resident # 12 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions. Resident # 12 was coded as being independent and not requiring set up by staff members for activities of daily living.</p> <p>The physician's order sheet (POS) dated February 2019 for Resident # 12 documented, "Novolin (Insulin). Inject 5 units subcutaneously (8) two times a day for diabetes. May hold if blood sugar is less than 100. Order Date: 02/13/2019."</p>	F 658			

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F 658	<p>Continued From page 103</p> <p>The physician's order sheet (POS) dated April 2019 for Resident # 12 documented, "Novolin (Insulin). Inject 5 units subcutaneously two times a day for DM (diabetes mellitus) give before breakfast and dinner. May hold if blood sugar is less than 100. Order Date: 03/26/2019."</p> <p>The eMAR (electronic medication administration record) dated February 2019 for Resident # 12 documented, "Novolin (Insulin). Inject 5 units subcutaneously two times a day for diabetes. May hold if blood sugar is less than 100." Further review of the eMAR revealed Novolin was administered on 02/15/19 with blood sugar of 75, on 02/16/19 with blood sugar of 91, 02/20/19 with blood sugar of 85, 02/27/19 with blood sugar of 94 and 77 and on 02/28/19 with blood sugar of 84.</p> <p>The eMAR (electronic medication administration record) dated April 2019 for Resident # 12 documented, "Novolin (Insulin). Inject 5 units subcutaneously two times a day for DM (diabetes mellitus) give before breakfast and dinner. May hold if blood sugar is less than 100." Further review of the eMAR revealed Novolin was administered on 04/16/19 with blood sugar of 91, 04/29/19 with blood sugar of 96 and on 04/30/19 with blood sugar of 69.</p> <p>The comprehensive care plan for Resident # 12 dated 01/21/2019 documented, "Focus. Endocrine System related to; insulin Dependent Diabetes." Under "Interventions" it documented, "Administer medication per physician orders. Date Initiated 01/21/2019."</p> <p>On 05/02/19 at 12:38 p.m., an interview was conducted with RN (registered nurse) # 6, unit manager. When asked to describe the check</p>	F 658			



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F 658	<p>Continued From page 104</p> <p>marks on the eMARS RN # 6 stated, "It means it was given." After reviewing Resident # 12's physician's order sheets dated February and April 2019 and the eMARS dated February and April where the insulin was administered with blood sugars below 100, RN # 6 stated, "Based on the word 'May' it should have been clarified." The reason there are parameters is to avoid a negative outcomes. Resident has not had negative effects from receiving the insulin with the blood sugar below 100."</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (administrative staff member) # 1, the interim administrator and ASM # 2, mobile administrator, ASM # 3, executive director of the assisted living facility, and ASM # 4, director of nursing were made aware of the findings.</p> <p>According to "Lippincott Manual Of Nursing Practice", Eighth Edition: by Lippincott Williams &amp; Wilkins, pg. 15, read: "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. . . Call the attending physician, discuss your concerns with him, obtain appropriate..orders. c. Notify all involved medical and nursing personnel.... d. Document clearly."</p> <p>No further information was provided prior to exit.</p> <p>References: (1) With type 1 diabetes, your pancreas does not make insulin. Insulin is a hormone that helps glucose get into your cells to give them energy. Without insulin, too much glucose stays in your blood. If you have type 1 diabetes, you will need to take insulin. Type 2 diabetes, the most common type, can start when the body doesn't</p>	F 658			

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F 658	<p>Continued From page 105</p> <p>use insulin as it should. If your body can't keep up with the need for insulin, you may need to take pills. Along with meal planning and physical activity, diabetes pills help people with type 2 diabetes or gestational diabetes keep their blood glucose levels on target. Several kinds of pills are available. Each works in a different way. Many people take two or three kinds of pills. Some people take combination pills. Combination pills contain two kinds of diabetes medicine in one tablet. Some people take pills and insulin. This information was obtained from the website: <a href="https://medlineplus.gov/diabetesmedicines.html">https://medlineplus.gov/diabetesmedicines.html</a>.</p> <p>(2) Blood sugar, or glucose, is the main sugar found in your blood. It comes from the food you eat, and is your body's main source of energy. Your blood carries glucose to all of your body's cells to use for energy. This information was obtained from the website: <a href="https://medlineplus.gov/bloodsugar.html">https://medlineplus.gov/bloodsugar.html</a>.</p> <p>(3) Lung cancer is cancer that starts in the lungs. The lungs are located in the chest. When you breathe, air goes through your nose, down your windpipe (trachea), and into the lungs, where it flows through tubes called bronchi. Most lung cancer begins in the cells that line these tubes. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/007270.htm">https://medlineplus.gov/ency/article/007270.htm</a>.</p> <p>(4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the</p>	F 658			

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F 658	Continued From page 106 website: <a href="https://medlineplus.gov/ency/article/003213.htm">https://medlineplus.gov/ency/article/003213.htm</a> .  (5) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/gerd.html">https://www.nlm.nih.gov/medlineplus/gerd.html</a> .  (6) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/003200.htm">https://medlineplus.gov/ency/article/003200.htm</a> .  (7) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/003200.htm">https://medlineplus.gov/ency/article/003200.htm</a> .  (8) The term "cutaneous" refers to the skin. Subcutaneous means beneath, or under, all the layers of the skin. For example, a subcutaneous cyst is under the skin. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/002297.htm">https://medlineplus.gov/ency/article/002297.htm</a> .	F 658			
F 684 SS=E	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	F 684		5/23/19	

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F 684	<p>Continued From page 107</p> <p>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:</p> <p>Based on observation, staff interview, facility document review and clinical record review it was determined the facility staff failed to ensure one of 56 sampled residents, (Resident #89), received care and services in accordance with professional standards and the comprehensive care plan.</p> <p>The facility staff failed to ensure continuity of care and collaboration with hospice care services for Resident # 89.</p> <p>The findings include:</p> <p>Resident # 89 was admitted to the facility on 08/16/2018 with diagnoses that included but were not limited to benign prostatic hyperplasia (1), Parkinson's disease (2), and hypertension (3).</p> <p>Resident # 89's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/29/2019, coded Resident # 89 as scoring a 3 (three) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions. Resident # 89 was coded as requiring extensive assistance of one staff member for activities of daily living. Section O "Special Treatments, Procedures and Programs" coded Resident # 89 as "K. Hospice Care."</p> <p>The POS (physician's order sheet) dated 03/31/2019 for Resident # 89 documented,</p>	F 684	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p style="text-align: center;">F-864</p> <p>It is the intended practice of the facility to ensure continuity of care and collaboration with hospice care services in accordance with professional standards.</p> <ol style="list-style-type: none"> <li>1. Resident #89 hospice evaluation and progress notes were placed in the resident's chart on May 2, 2019.</li> <li>2. Residents who are being followed by hospice and reside in the facility have the potential to be affected.</li> <li>3. Licensed Nurses and the Interdisciplinary Team (IDT) were re-educated on the collaboration with hospice care services in accordance with professional standards.</li> </ol>		

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F 684	<p>Continued From page 108</p> <p>"Admit to (Name of Hospice). Order Date: 03/18/2019."</p> <p>The comprehensive care plan for Resident # 89 documented, "Focus: Hospice/Palliative care. Date Initiated: 04/04/2019." Under "Interventions" it documented, "Administer medication per physician orders. Allow patient/family to discuss feelings, etc. Assist patient or surrogate to make advanced directive choices as needed. Date Initiated: 04/04/2019: Honor advance directive. Date Initiated: 04/04/2019; Hospice staff to visit to provide care, assistance, and/or evaluation. Date Initiated: 04/04/2019." Further review of the comprehensive care plan for Resident # 89 documented, "Focus: Pain evidenced by verbalization of pain related to knee pain/osteoarthritis. Date Initiated: 08/17/2018." Under "Interventions" it documented, "Report GI (gastro-intestinal) distress secondary to analgesia such [sic] nausea, constipation, diarrhea. Date Initiated: 08/17/2018; Report nonverbal expressions of pain as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc. Date Initiated: 08/17/2018: Administer pain medication per physician order. Date Initiated: 08/17/2019, Encourage/assist to reposition frequently to position of comfort. Date Initiated: 08/17/2018, Notify physician if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective. Date Initiated: 08/17/2018."</p> <p>Review of the clinical record and the EHR (electronic health record) for Resident # 89 failed to evidence the "(Name of Hospice) Nursing Comprehensive Admission Assessment, (Name of Hospice) Interdisciplinary Plan of Care, (Name of Hospice) Nursing Clinical Notes and (Name of</p>	F 684	<p>4. Director of Nursing and/or designee will audit hospice residents to ensure evaluations and progress notes are readily available on the resident's chart. These audits will be done daily x 5 days and then 3 days a week x 3 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated.</p> <p>5. The facility alleged date of compliance is June 11, 2019.</p>		

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F 684	<p>Continued From page 109 Hospice) Hospice Aide Visit Notes."</p> <p>Review of the facility's nursing "Progress Notes" for Resident # 89 dated 03/18/19 through 05/01/19 failed to evidence documentation of visits from (Name of Hospice) nurse.</p> <p>On 05/01/19 at 10:18 a.m., a requested was made to RN (registered nurse) # 6, unit manager on station six, for the hospice notes, hospice initial evaluation and hospice care plan for Resident # 89. RN # 6 reviewed Resident # 89's clinical record and stated that she does not have them in his clinical record and she would call (Name of Hospice) regarding the notes and have them faxed to the facility. When asked if the hospice notes should be a part of the Resident # 89's clinical record, RN # 6 stated, "I would think so." When asked how the hospice nurse informs the staff of Resident # 89's hospice care, RN # 6 stated, "I'm usually here when the hospice nurse comes here and she will let me know if there are any changes or any new orders. If I'm not available she will tell the charge nurse."</p> <p>On 05/01/19 at 1:50 p.m., a telephone interview was conducted with the OHM (other staff member) # 11, (Name of Hospice) nurse and OHM # 10, (Name of Hospice) secretary. When asked to describe how the hospice documentation is provided to the facility for Resident # 89, OSM # 10 stated, "The notes are printed every two weeks and they are given to the nurse to bring them to the facility on their next visit." When asked about Resident # 89's missing evaluation from hospice and the hospice nurses notes, OSM # 11 stated, "They should have the evaluation and notes. The hospice nurse and the nurse at the facility talk at each</p>	F 684			

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F 684	<p>Continued From page 110</p> <p>visit but there should be note from each visit." During the interview with OSM # 10 and OSM # 11, RN # 6 reviewed Resident # 89's clinical record for the hospice documentation. RN # 6 stated that she was unable to locate any of the hospice documentation for Resident # 89 and this was conveyed to OSM #10 and #11. OSM # 11 then stated that she would fax the hospice documentation for Resident # 89 to the facility and then requested to speak to RN # 6 to obtain the facility's fax number.</p> <p>On 05/01/19 at 2:20 p.m., ASM (administrative staff member) # 2, mobile administrator, provided this surveyor with a three ring binder that documented, "(Name of Hospice) for (Resident # 89)." When asked where the binder came from ASM # 2 stated that RN # 6 would explain and that she was just informed to give it to this surveyor.</p> <p>On 05/01/19 at approximately 2:22 p.m., a brief interview was conducted with RN # 6. When asked where the (Name of Hospice) binder for Resident # 89 came from, RN # 6 stated, "Hospice dropped off the binder at the front desk."</p> <p>Review of the (Name of Hospice) binder for Resident # 89 revealed the following: "(Name of Hospice) Nursing Comprehensive Admission Assessment" dated 03/18/19, "(Name of Hospice) Interdisciplinary Plan of Care" dated 03/18/19, "(Name of Hospice) Nursing Clinical Notes" dated 03/20/19 through 04/20/19 and "(Name of Hospice) Hospice Aide Visit Notes" dated 03/20/19 through 04/24/19.</p>	F 684			

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F 684	Continued From page 111 On 05/02/19 at 11:56 a.m., an interview was conducted with RN # 6 regarding the continuity of care and collaboration of Resident # 89's hospice care. When asked how often Resident # 89 is visited by the hospice nurse, RN # 6 stated, "Once a week." When asked if the statement she made the previous day regarding the communication with the hospice nurse, "When the hospice nurse is here she will verbally tell me of any changes with resident before she leave or the charge nurse if I'm not available" was an accurate account, RN # 6 stated "Yes." When asked if verbal communication once a week and not having weekly documentation from hospice provide comprehensive communication and collaboration for Resident # 89's hospice care, RN # 6 stated, "No, It's not comprehensive communication or collaboration." When asked how effective continued communication and collaboration could be established when there was missing hospice notes, RN # 6 stated, "We would have to call them weekly." After reviewing Resident # 89's comprehensive care plan, RN #6 was asked if the care plan identified non-pharmacological interventions to address Resident # 89's pain. RN # 6 stated, "Yes, to reposition frequently to position of comfort." When asked if that was the only intervention that was being used by staff to address Resident # 89's pain, RN # 6 stated, "He also has a stuffed dog that he likes that provides comfort for him and he likes watching others so we bring him out to the nurse's station. These are diversionary activities." When asked if these interventions should be a part of the comprehensive care plan for Resident # 89, RN # 6 stated, "Yes." When asked if his care plan is comprehensive for pain, RN # 6 stated, "No." When asked if Resident # 89 has had a care plan meeting since his	F 684			



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F 684	<p>Continued From page 112</p> <p>admission to hospice care and if the nurse from (Name of Hospice) had attended the care plan meeting, RN # 6 stated, "Yes on April 16 and no the hospice nurse was not there." When asked if the hospice nurse should be involved in the Resident # 89's care plan review meeting to maintain the continuity of care, RN # 6 stated, "Yes." When asked why it was important for the hospice nurse to be in involved in attending the care plan meetings, RN # 6 stated, "Because they have the primary, care and ordered medications for the resident and the rapport with the family and they can provide a complete picture of the resident's care."</p> <p>When asked about information in the three ring binder that documented, "(Name of Hospice) for (Resident # 89)" that was provided to this surveyor on 05/01/19 at 2:20 p.m., RN # 6 stated, "It contained, the hospice care plan, nurse and nurse aide notes." When asked if that documentation was in the facility, RN # 6 stated, "No. It was not available prior to it being provide dropped off." RN #6 was asked to describe the information and process required to establish the continuity of care and collaboration with hospice services. RN # 6 stated, "The hospice nurse does communicate when they visit and it would be given to the charge nurse and a note would be made by the facility nurse that the hospice nurse was in to visit and it would document any changes of condition would be noted, any new meds (medications) and/or any changes in orders. That information would then be communicated to other staff, the on-coming facility nurses." When asked if this this process was being followed for Resident # 89, RN # 6 reviewed the hospice notes and the facility progress notes and stated, "No." After reviewing</p>	F 684			

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F 684	<p>Continued From page 113</p> <p>the hospice documentation for Resident # 89, RN # 6 was asked if she had the names and contact information for the hospice personnel involved in hospice care of Resident # 89. RN # 6 stated, "No." When asked if she had instructions on how to access the hospice's 24-hour on-call system, RN # 6 stated, "No, I just have the main contact number."</p> <p>The "Nursing Facility Agreement" with the (Name of Hospice) dated "January 1, 2016" documented, "Term and Renewal. The initial term of this agreement is one year and it begins on the date of this Agreement. This agreement will renew automatically for additional one year terms unless terminated pursuant to section 12." Under "4.8 Plan of Care" it documented, "Hospice will collaborate with Facility on a coordinated Plan of Care developed jointly between Hospice and Facility. Each Hospice Patient's written Plan of Care must include both the most recent Hospice Plan of Care and a description of the services furnished by Facility to attain or maintain the Hospice Patient's highest practicable physical, mental, and psychosocial well-being. Facility will perform all services described in this Agreement in accordance with Facility's protocols, policies and procedures to the extent they are consistent with Hospice protocols, policies and procedure, and Hospice's Plan of Care for each Hospice Patient. Facility agrees to abide by patient care protocols for palliative medicine established by Hospice and to collaborate with the Hospice Interdisciplinary Team prior to decisions for treatment or diagnostic procedures." Under "4.9 Resident Chart" it documented, "Facility and Hospice will prepare and maintain complete medical records for Hospice Patients receiving Facility services in accordance with this</p>	F 684			

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F 684	<p>Continued From page 114</p> <p>Agreement and will include all treatments, progress notes, authorizations, physician orders and other pertinent information. Copies of all documents of services provided by Hospice will be filed and maintained in the Facility chart. Facility will provide Hospice with a copy of the clinical record upon request. Originals of all documents for services provided by Hospices will be filed and maintained by Hospice at the Hospice office. Facility and Hospice will each have access to the Hospice Patient's records maintained by the other party for verification of patient care and financial information pertinent to the Agreement. Access to Hospice Patient's records will be provided during routine hours of business and each party will give reasonable notice to the other of its intent to review such records."</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (administrative staff member) # 1, the interim administrator and ASM # 2, mobile administrator, ASM # 3, executive director of the assisted living facility, and ASM # 4, director of nursing were made aware of the findings.</p> <p>No further information was provided prior to exit.</p> <p>References: (1) An enlarged prostate. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html">https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html</a>.</p> <p>(2) High blood pressure. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/highbloodpressure.html">https://www.nlm.nih.gov/medlineplus/highbloodpressure.html</a>.</p>	F 684			

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F 686 F 686 SS=D	Continued From page 115 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 and clinical record review, it was determined that the facility staff failed to provide the necessary treatment and services, consistent with professional standards of practice, to promote healing, and prevent infection of a pressure injury for one of 56 residents in the survey sample, Resident 65.  The facility staff failed to provide a clean barrier under Resident # 65's right heel and failed to prevent the heel from coming into contact with a contaminated area.  The findings include:  Resident # 65 was admitted to the facility on 01/13/11 with diagnoses that included but were not limited to Alzheimer's disease (1), diabetes mellitus, (2), hypertension (3) and depressive	F 686 F 686	The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.  F-686 It is the intended practice of the facility to provide the necessary treatment and services, consistent with professional standards of practice, to promote healing, and prevent infection of a pressure injury.	5/23/19	

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F 686	<p>Continued From page 116 disorder (4).</p> <p>Resident # 65's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/12/19, failed to coded Resident # 65 on the brief interview for mental status (BIMS). Resident # 65 was coded as being totally dependent of one staff member for activities of daily living. Section M "Skin Conditions)" coded Resident # 65 as having a "Stage 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of the tissue loss. May include undermining and tunneling." Under "M1200 Skin and Ulcer/Injury Treatment" it documented, "Pressure ulcer/injury care." The annual MDS assessment with an ARD (assessment reference date) of 12/12/18 coded Resident # 65 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions.</p> <p>On 05/02/19 at approximately 8:50 a.m., an observation was conducted of RN (registered nurse) # 8, the wound care nurse, performing a dressing change on Resident # 65's right heel. Resident # 65 was lying in his bed; RN # 8 assessed Resident # 65 for pain and set up a clean barrier sheet over Resident # 65's over-the-bed-table after disinfecting it. RN # 8 then placed the clean dressings and treatments on the over-the-bed-table. After donning a clean pair of gloves, RN # 8 removed the Prevalon (5) boot from Resident # 65's right foot and placed it under his calf, then removed the old gauze wrapped around Resident # 65 ankle and heel. When attempting to remove the foam bandage</p>	F 686	<ol style="list-style-type: none"> <li>1. Resident #65 still resides in the facility.</li> <li>2. Residents with pressure ulcers have the potential to be affected.</li> <li>3. Wound care nurse was re-educated on May 1, 2019 regarding a non-sterile dressing change to include use of a barrier. Licensed Nurses were re-educated on the procedure of non-sterile dressing changes including use of a barrier.</li> <li>4. Director of Nursing and/or designee will audit 2 residents who have pressure ulcer dressing changes for use of barriers daily x 5 days and then 3 days a week and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated.</li> <li>5. The facility alleged date of compliance is June 11, 2019.</li> </ol>		

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F 686	Continued From page 117 covering the heel, Resident # 65 yelled in pain, RN # 8 immediately stopped the process, asked Resident # 65 if it hurt, Resident # 65 stated yes. RN # 8 then obtained a vile of normal saline, informed Resident # 65 the he would apply the saline over the wound and the bandage to loosen the adhesive from his skin. Without pacing a clean barrier under Resident # 65's right foot/heel, RN #8 poured the saline over the wound and bandage and slowly removed the bandage from Resident # 65's heel. Observation of this process revealed the saline running over the heel wound and old bandage and running on to Resident # 65's fitted sheet that was over his mattress. When the bandage was removed, RN # 8 was asked to describe the wound. RN # 8 stated, "It measured 4.2 millimeters long and 4.3 millimeters wide, 40% granulation tissue, small amount of drainage, no odor, painful to the touch, and 60 % epithelial." Observation of the bed sheet under Resident # 65's right heel revealed the area was soaked from the saline poured over the open wound and contained a small amount a blood. After taking the wound measurements, RN # 8 placed Resident # 65's right heel directly on the wet area on the mattress where the wound was rinsed. RN # 8 then cleaned the wound with a clean four-by-four gauze with clean saline, placed the heel back on the wet area on the bed, retrieved the treatment, medihoney (6) from the over-the-bed-table, applied it to the wound, placed the residents heel back in the same position on the bed, retrieved a clean dressings and wrapped the wound. RN # 8 placed Resident # 65's right foot back into the Prevalon boot placed it on the wet area on the bed and covered Resident # 65's legs with a blanket. Further observation failed to evidence RN # 8 changing the fitted sheet on Resident # 65's bed or	F 686			

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F 686	<p>Continued From page 118</p> <p>requesting that a CNA (certified nursing assistant) or a another nurse change it, and left the wet area on the sheet.</p> <p>On 05/02/19 at 2:29 p.m., an interview was conducted with RN # 8, the wound care nurse regarding infection control practices during wound care. RN #8 was asked what infection control procedures are implemented during wound care. RN # 8 stated, "The use of gloves, wash hands between tasks, keeping items in zip lock bags to secure supplies/treatments from the environment, using sanitizing wipes to clean the work surfaces, use clean barriers such as a clean towel or clean brief as a barrier to keep the bed clean." RN #8 was asked about providing a clean barrier and keeping Resident # 65's heel from touching the contaminated area on Resident # 89's bed and below his heel during the wound care, he provided. RN # 8 stated, "I should have used a clean barrier under the foot or had someone come in and help hold up his foot and the bed sheet should have been cleaned and the mattress wiped down."</p> <p>The facility's policy "Dressing Change: Non Sterile (Clean) documented, "11. Place procedure towel (wound drape) or clean towel under area for treatment."</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (administrative staff member) # 1, the interim administrator and ASM # 2, mobile administrator, ASM # 3, executive director of the assisted living facility, and ASM # 4, director of nursing were made aware of the findings.</p> <p>No further information was provided prior to exit.</p>	F 686			

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F 686	Continued From page 119 References: (1) A brain disorder that seriously affects a person's ability to carry out daily activities). This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/alzheimersdisese.html">https://www.nlm.nih.gov/medlineplus/alzheimersdisese.html</a> .  (2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/003213.htm">https://medlineplus.gov/ency/article/003213.htm</a> .  (3) Low blood pressure. This information was taken from the website: <a href="https://medlineplus.gov/lowbloodpressure.html">https://medlineplus.gov/lowbloodpressure.html</a> .  (4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm">https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm</a> .  (5) Was specifically designed to address the problem of patient movement and its negative effect on heel offloading. Prevalon's unique dermasuede fabric interior gently grips the limb so it remains fully offloaded, even when the patient is moving. This information was obtained from the website: <a href="https://www.medline.com/product/Prevalon-Heel-Protectors-by-Sage-Products/Z05-PF26037">https://www.medline.com/product/Prevalon-Heel-Protectors-by-Sage-Products/Z05-PF26037</a> .  (6) Honey can become contaminated with germs from plants, bees, and dust during production,	F 686			



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F 686	Continued From page 120 collection, and processing. Fortunately, there are characteristics of honey that prevent these germs from remaining alive or reproducing. However, some bacteria that reproduce using spores, such as the type that causes botulism, can remain. This explains why botulism has been reported in infants given honey by mouth. To solve this problem, medical-grade honey (Medihoney, for example) is irradiated to inactivate the bacterial spores. Medical-grade honey is also standardized to have consistent germ-fighting activity. Some experts also suggest that medical-grade honey should be collected from hives that are free from germs and not treated with antibiotics, and that the nectar should be from plants that have not been treated with pesticides. This information was obtained from the website: <a href="https://medlineplus.gov/druginfo/natural/738.html">https://medlineplus.gov/druginfo/natural/738.html</a> .	F 686			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)  §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.  §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 690		5/23/19	

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F 690	<p>Continued From page 121</p> <p>indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview and clinical record review, it was determined that facility staff failed to provide appropriate treatment and services for a suprapubic catheter for one of 56 residents in the survey sample, Residents # 127.</p> <p>The facility staff failed to prevent Resident # 127's catheter collection bag and tubing from resting on the floor.</p> <p>The findings include:</p> <p>Resident #127 was admitted to the facility on 04/04/19, with diagnoses that included but were not limited to: hypertension (1), coronary artery diseases (CAD) (2), and dementia (3).</p> <p>The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 04/15/19, coded</p>	F 690	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p style="text-align: center;">F-690</p> <p>It is the intended practice of the facility to ensure that a resident has appropriate services and treatment for foley catheters.</p> <p>1. Resident #127 foley bag and tubing were immediately changed on May 1,</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 690	<p>Continued From page 122</p> <p>the resident as scoring a 7 on the BIMS (brief interview for mental status) score of 0-15, 7 indicating severe cognitive impairment for daily decision-making. The resident was coded as being totally dependent upon two or more staff members for all of his activities of daily living. Section H "Bladder and Bowel" Resident # 127 was coded as "A. Indwelling catheter (including suprapubic catheter [5] and nephrostomy tube)."</p> <p>On 04/30/19 11:42 a.m., an observation of Resident #127's room revealed the resident resting in bed. Further observation revealed a urinary catheter collection bag hanging on the side of the resident's bed with the urine collection bag touching the floor. The resident's bed was observed at a low position.</p> <p>On 05/01/19 09:14 a.m., an observation of Resident #127's room revealed the resident resting in bed. Further observation revealed a urinary catheter collection bag hanging on the side of the resident's bed with the urine collection bag touching the floor.</p> <p>On 05/01/19 at 1:20 p.m., an observation of Resident #127's room was conducted with LPN #7. Observation revealed a urinary catheter collection bag hanging on the side of the resident's bed with the urine collection bag touching the floor. When asked if the urinary catheter bag should be touching the floor, LPN #7 stated, "No." when asked where the urinary drainage bag should be positioned when the resident is in bed, LPN stated, "It should be below the level of the resident but not on the floor, that is not right." LPN #7 raised Resident #127's bed to get the urinary catheter bag off the floor. When asked why the urinary catheter bag should not be</p>	F 690	<p>2019 after having contact with the floor.</p> <ol style="list-style-type: none"> <li>Residents that have foley catheters and reside in the facility have the potential to be affected.</li> <li>Nursing staff was re-educated on catheter care to include keeping the bag/tubing off of the floor.</li> <li>Director of Nursing and/or designee will audit residents with foley catheters to ensure bag/tubing is not resting on the floor This will be done daily x 5 days and then 3 days a week x 3 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated.</li> <li>The facility alleged date of compliance is June 11, 2019.</li> </ol>		

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F 690	<p>Continued From page 123 on the floor, LPN #7 stated, "to prevent infection."</p> <p>Review of the facility policy titled "catheter care: Indwelling catheter" documented in part, "16. Check the tubing is not kinked, looped, clamped, or positioned above the level the bladder and off the floor. Place bag in catheter dignity bag."</p> <p>According to Lippincott Manual of Nursing Practice, Eighth Edition 2006, chapter 21, Renal and Urinary Disorders, page 757, "Maintaining a Closed Urinary Drainage System: Many UTI's (urinary tract infections) are due to extrinsically acquired organisms transmitted by cross-contamination. 2. c. Keep the drainage bag off the floor to prevent bacterial contamination".</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (Administrative Staff Member) #2, the mobile administrator, and ASM #4, the director of nursing, were made aware of the above findings.</p> <p>No further information was provided prior to exit</p> <p>References:</p> <ol style="list-style-type: none"> <li>1. High blood pressure. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/highbloodpressure.html">https://www.nlm.nih.gov/medlineplus/highbloodpressure.html</a>.</li> <li>2. A common type of heart disease. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html">https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html</a></li> <li>3. A loss of brain function that occurs with certain diseases. It affects memory, thinking, language,</li> </ol>	F 690			

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F 690	Continued From page 124 judgment, and behavior. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/000739.htm">https://medlineplus.gov/ency/article/000739.htm</a> .	F 690			
F 695 SS=D	5. A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly. You may need a catheter because you have urinary incontinence (leakage), urinary retention (not being able to urinate), surgery that made a catheter necessary, or another health problem. This information was obtained from the website: <a href="https://medlineplus.gov/ency/patientinstructions/000145.htm">https://medlineplus.gov/ency/patientinstructions/000145.htm</a>  Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)  § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of 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 the facility staff failed to provide respiratory care and services consistent with professional standards of practice for two of 56 residents in the survey sample, Resident #72 and Resident #127.  1. The facility staff failed to provide oxygen according to the physicians order for Resident	F 695	The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or	5/23/19	

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F 695	<p>Continued From page 125 #72.</p> <p>2. The facility staff failed to ensure Resident # 127's nasal cannula was stored in a sanitary manner when not in use.</p> <p>The findings include:</p> <p>1. The facility staff failed to provide oxygen according to the physicians order for Resident #72.</p> <p>Resident #72 was admitted to the facility on 12/28/11 and readmitted on 3/5/19. Diagnoses included but were not limited to: atrial fibrillation (1), chronic obstructive pulmonary disease (COPD) (2), anemia and weakness.</p> <p>The most recent MDS (minimum data set), a Medicare fourteen day assessment, with an ARD (assessment reference date) of 3/17/19 coded the resident as having a score of 5 out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely cognitively impaired. Section O0100 documented Resident #72's oxygen use.</p> <p>The physician order dated 3/6/19 documented, "O2 (Oxygen) at 3 liters per minute via NC (nasal cannula) to maintain O2 saturation &gt;90%."</p> <p>Review of the residents MAR (medication administration record) dated April 2019 documented, "O2 (Oxygen) at 3 liters per minute via NC (nasal cannula) to maintain O2 saturation &gt;90%." Oxygen was documented as administered during the month of April.</p> <p>On 04/30/19 at approximately 1:44 p.m., an</p>	F 695	<p>will be corrected by the date or dates indicated.</p> <p><b>F-695</b></p> <p>It is the intended practice of the facility to provide respiratory care and services consistent with professional standards of practice.</p> <p>1. Resident #72 had oxygen tubing replaced on May 1, 2019. Resident #127 had oxygen adjusted to 3 liters on May 1, 2019.</p> <p>2. Residents that are on oxygen and reside in the facility have the potential to be affected.</p> <p>3. Nursing staff were re-educated on respiratory care and services consistent with professional standards of practice.</p> <p>4. Director of Nursing and/or designee will audit residents who are on oxygen daily x 5 days and then 3 days a week x 3 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated.</p> <p>5. The facility alleged date of compliance is June 11, 2019.</p>		

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 695	<p>Continued From page 126</p> <p>observation was made of Resident #72. Resident #72 was seated in her wheelchair wearing a nasal cannula attached to an oxygen concentrator. The oxygen concentrator flow rate was observed set between 2.5 and 3L/min (liters/min) oxygen.</p> <p>On 04/30/19 at approximately 4:07 p.m., a second observation was made of Resident #72. Resident #72 was again wearing a nasal cannula that was attached to an oxygen concentrator. Resident #72 oxygen concentrator flow rate was again set between 2.5 and 3L/min oxygen.</p> <p>On 04/30/19 at approximately 04:09 p.m., a third observation was made of Resident #72 with LPN (licensed practical nurse) #6. Resident #72 was again wearing a nasal cannula that was attached to an oxygen concentrator. The oxygen-concentrator flow rate was again set between 2.5 and 3L/min oxygen.</p> <p>On 04/30/19 at approximately 04:10 p.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 was asked how an oxygen concentrator flow meter should be set. LPN #4 replied, "First you look the MD's (medical doctor) order, then get down to eye level and turn the knob until the middle of the ball floats up to the liter per minute line the doctor ordered." When asked where should the ball be in relation to the line. LPN #6 replied, "It should sit on top of the line."</p> <p>On 05/01/19 at approximately 3:02 p.m., an interview was conducted with RN (register nurse) #5. When asked how an oxygen flow meter is set. RN #5 replied, "You should check the MD's order, then go to the machine get down eye level and adjust the knob until the middle of the ball is on</p>	F 695			

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F 695	<p>Continued From page 127 the line that was ordered."</p> <p>According to the facilities oxygen administration policy "For oxygen concentrator, plug in power cord, turn on and set flow meter to correct flow rate."</p> <p>According to the Perfecto2 Series user manual page 19 for the oxygen concentrator that was at Resident #72's bedside, "To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now center the ball on the L/min line prescribed."</p> <p>On 05/02/19 at approximately 1:00 p.m., ASM (administrative staff member) #1, the Interim Administrator, ASM #2, the Mobile Administrator and ASM #3, the Assisted Living Facility (ALF) Executive Director were made aware of the findings.</p> <p>No further information was provided prior to exit.</p> <p>1. Atrial fibrillation is one of the most common types of arrhythmias, which are irregular heart rhythms. Atrial fibrillation causes the heart to beat much faster than normal, and the upper and lower chambers of the heart do not work together. When this happens, the lower chambers do not fill completely or pump enough blood to the lungs and body. This can make you feel tired or dizzy, or you may notice heart palpitations or chest pain. Blood also pools in the heart, which increases your risk of having a stroke or other complications. This information was obtained from the website: <a href="https://www.nhlbi.nih.gov/health-topics/atrial-fibrillation">https://www.nhlbi.nih.gov/health-topics/atrial-fibrillation</a></p>	F 695			



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F 695	<p>Continued From page 128</p> <p>2. Disease that makes it difficult to breath that can lead to shortness of breath). The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/copd.html">https://www.nlm.nih.gov/medlineplus/copd.html</a>.</p> <p>2. The facility staff failed to ensure Resident # 127's nasal cannula was stored in a sanitary manner when not in use.</p> <p>Resident #127 was admitted to the facility on 04/04/19, with diagnoses that included but were not limited to: hypertension (1), coronary artery diseases (CAD) (2), and dementia (3).</p> <p>The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 04/15/19, coded the resident as scoring a 7 on the BIMS (brief interview for mental status) score of 0-15, 7 indicating severe cognitive impairment for daily decision-making. The resident was coded as totally dependent upon two or more staff members for all of activities of daily living. In Section O- Special treatments and programs, the resident was coded C. oxygen therapy.</p> <p>04/30/19 11:42 a.m., an observation of Resident #127's room revealed a nasal cannula (4) oxygen device on the floor uncovered.</p> <p>On 04/30/19 at 2:36 p.m. and on 05/01/19 8:11 a.m., an observation of the resident's room revealed the resident was in bed receiving</p>	F 695			

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F 695	<p>Continued From page 129</p> <p>oxygen by nasal cannula connected to an oxygen concentrator.</p> <p>On 05/01/19 at 9:46 a.m., an observation of Resident #127's room revealed the resident sitting on his bed finishing his breakfast. Resident 127's nasal cannula was observed resting on the floor uncovered.</p> <p>On 05/01/19 01:20 p.m., an interview was conducted with LPN #7. When asked about the process of storing respiratory equipment specifically a nasal cannula when not in use, LPN #7 stated, "It should be bagged and labeled with the resident's name, room number, the date." When asked if the nasal cannula should be on the floor uncovered, LPN #7 stated, "No." When asked why a nasal cannula should not be on the floor, LPN #7 stated, "To prevent infection to the resident."</p> <p>The physician orders dated 04/05/19 documented, "O2 (oxygen) 2 (two) liters per minute via (by) nasal cannula every shift for hypoxia."</p> <p>Review of Resident #127's electric clinical record on 05/01/19 failed to evidence a comprehensive care plan for the use of oxygen.</p> <p>The review of the facility policy titled, "Oxygen administration." Documented in part under completion of procedure, "2. When oxygen not in use, store oxygen tubing and nasal cannula or mask in separate, labeled plastic bag."</p> <p>No further information was provided prior to exit.</p> <p>Reference:</p>	F 695			

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F 695	Continued From page 130  1. High blood pressure. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/highbloodpressure.html">https://www.nlm.nih.gov/medlineplus/highbloodpressure.html</a> .  2. A common type of heart disease. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html">https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html</a>  3. A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/000739.htm">https://medlineplus.gov/ency/article/000739.htm</a> .  4. Tubing used to deliver oxygen at levels from 1 to 6 L/min. The nasal prongs of the cannula extend approx. 1 cm into each naris and are connected to a common tube, which is then connected to the oxygen source. It is used to treat conditions in which a slightly enriched oxygen content is needed, such as emphysema. The exact percentage of oxygen delivered to the patient varies with respiratory rate and other factors. This information was obtained from the website: <a href="http://medical-dictionary.thefreedictionary.com/nasal+cannula">http://medical-dictionary.thefreedictionary.com/nasal+cannula</a> .	F 695			
F 697 SS=D	Pain Management CFR(s): 483.25(k)  §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,	F 697		5/23/19	

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 697	<p>Continued From page 131 and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident interview, staff interview and clinical record review, it was determined that facility staff failed to provide pain management for one of 56 residents in the survey sample, Residents # 12.</p> <p>The facility staff failed to implement non-pharmacological interventions prior to administering as needed pain medication to Resident #32.</p> <p>The findings include:</p> <p>Resident # 12 was admitted to the facility on 01/21/2019 with diagnoses that included but were not limited to malignant neoplasm of lung (1), depressive disorder (2), diabetes mellitus (3) gastroesophageal reflux disease (4), and convulsions (5).</p> <p>Resident # 12's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/28/19, coded Resident # 12 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions. Resident # 12 was coded as being independent and not requiring set up by staff members for activities of daily living. Section "J0600 Pain Intensity. Ask resident "Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine" coded Resident # 12 as "8 (eight)."</p> <p>On 04/30/19 at 4:14 p.m., an observation of LPN</p>	F 697	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p style="text-align: center;">F- 697</p> <p>It is the intended practice of the facility to ensure that non-pharmacological intervention is provided prior to administration of PRN pain medication.</p> <ol style="list-style-type: none"> <li>1. Resident #12 medication administration record and documentation were reviewed.</li> <li>2. Residents that are ordered PRN pain medication and reside in the facility have the potential to be affected.</li> <li>3. Licensed Nurses were re-educated on the pain process and non-pharmacological interventions are provided prior to the administration of PRN pain medication.</li> <li>4. The Director of Nursing and/or designee will audit medication</li> </ol>		

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 697	<p>Continued From page 132</p> <p>(licensed practical nurse) # 5 revealed she entered Resident # 12's room and asked him his pain level. Resident # 12 stated, "Nine." LPN # 5 walked out of Resident # 12's room, went to her medication cart, obtained a pain medication, went back into Resident # 12's room informed him that he was receiving Roxicodone and then administered the medication to the resident. Further observation failed to evidence LPN # 5 attempting non-pharmacological interventions prior to administering the pain medication to Resident # 12.</p> <p>The "Physician's Order Sheet" dated "04/30/2019" documented, "Roxicodone Tablet 5MG (milligram) (Oxycodone) (6). Give 1 (one) tablet by mouth every 6 (six) hours as needed for metastatic cancer of the brain. Order Date: 01/21/2019. Start Date: 01/21/2019."</p> <p>The eMAR (electronic medication administration record) dated "Apr (April) 2019" documented the above physician's order. Review of the eMAR revealed Roxicodone 5mg was administered on the following dates and times with pain levels as follows: 04/09/19 at 10:16 a.m., with a pain level of three, 04/15/19 at 5:05 p.m., with a pain level of nine, 04/17/19 at 12:24 p.m., with a pain level of four and at 6:27 p.m. with a pain level of ten, 04/19/19 at 4:40 p.m., with a pain level of nine, 04/23/19 at 3:55 p.m., with a pain level of nine, 04/29/19 at 6:29 p.m., with a pain level of five, 04/30/19 at 4:15 p.m., with a pain level of nine. Further review of the eMAR dated "Apr (April) 2019" failed to evidence documentation of non-pharmacological interventions prior to the administration of Roxicodone.</p>	F 697	<p>administration record and documentation of 5 residents to reflect the use of non-pharmacological intervention prior to giving PRN pain medication daily x 5 days and then 3 days a week x 3 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated.</p> <p>5. The facility alleged date of compliance is June 11, 2019.</p>		

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F 697	<p>Continued From page 133</p> <p>Review of the nurse's progress notes and the eMAR notes for Resident # 12 dated 04/01/19 through 04/30/19 failed to evidence documentation of non-pharmacological interventions prior to the administration of Roxycodone on the dates above.</p> <p>The comprehensive care plan for Resident # 12 dated 01/21/2019 documented, "Focus. Pain related to lung cancer with brain mets (metastatic). Date Initiated: 01/21/2019" Under "Interventions" it documented, "Encourage/Assist to reposition frequently to position of comfort. Date Initiated: 01/21/2019."</p> <p>On 04/30/19 at 3:58 p.m., an interview was conducted with Resident # 12. When asked where he has pain Resident # 12 stated, "I usually have pain in my side" and he pointed to his right side. When asked if the staff try to alleviate his pain by positioning or using hot or cold compresses before administering the pain medication Resident # 12 stated, "No they just give me the medication."</p> <p>On 05/02/19 at 10:08 a.m., an interview was conducted with LPN # 5. LPN #5 was asked to describe the process for administering as needed pain medication. LPN # 5 stated, "Ask the resident to rate pain level zero to ten, with ten being worse, check the eMAR and the last time they had they had pain medication and make sure it can be administered, if it's available administer it, reassess the resident in approximately an hour, try non-pharmacological approaches before giving the medication." When asked where staff document the non-pharmacological approaches attempted, LPN # 5 stated, "It is documented in the eMAR notes."</p>	F 697			

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F 697	<p>Continued From page 134</p> <p>When asked if she administered Roxicodone to Resident # 12 on 04/30/19, LPN # 5 stated, "Yes." When asked if she attempted non-pharmacological approaches before administering the medication, LPN # 5 stated, "No I didn't." After reviewing the eMAR notes for Resident # 12 dated 04/09/19 through 04/30/19, LPN # 5 was asked if non-pharmacological approaches had been attempted before the administration of Roxicodone. LPN # 5 stated that she didn't see it documented and couldn't say that it was being attempted.</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (administrative staff member) # 1, the interim administrator and ASM # 2, mobile administrator, ASM # 3, executive director of the assisted living facility, and ASM # 4, director of nursing were made aware of the findings.</p> <p>No further information was provided prior to exit.</p> <p>References:</p> <p>(1) Lung cancer is cancer that starts in the lungs. The lungs are located in the chest. When you breathe, air goes through your nose, down your windpipe (trachea), and into the lungs, where it flows through tubes called bronchi. Most lung cancer begins in the cells that line these tubes. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/007270.htm">https://medlineplus.gov/ency/article/007270.htm</a>.</p> <p>(2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks</p>	F 697			

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F 697	Continued From page 135 or more. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/003213.htm">https://medlineplus.gov/ency/article/003213.htm</a> .  (4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/gerd.html">https://www.nlm.nih.gov/medlineplus/gerd.html</a> .  (4) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/003200.htm">https://medlineplus.gov/ency/article/003200.htm</a> .  (5) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/003200.htm">https://medlineplus.gov/ency/article/003200.htm</a> .  (6) Are an immediate-release oral formulation of oxycodone hydrochloride indicated for the management of moderate to severe pain where the use of an opioid analgesic is appropriate. This information was obtained from the website: <a href="https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d48c22ff-bbb4-4a93-a35b-6eebff7b8e53">https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d48c22ff-bbb4-4a93-a35b-6eebff7b8e53</a> .	F 697			
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)  §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from	F 757		5/23/19	



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F 757	<p>Continued From page 136</p> <p>unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or</p> <p>§483.45(d)(2) For excessive duration; or</p> <p>§483.45(d)(3) Without adequate monitoring; or</p> <p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined the facility staff failed to ensure the medication regimen for two of 56 sampled residents, (Resident #26 and Resident #17) were free from unnecessary drugs.</p> <p>1. The facility staff failed administered insulin to Resident # 26's when the resident's blood sugar was below the physician ordered parameter of 150 on multiple dates in February, March and April 2019.</p> <p>2. The facility staff administered insulin to Resident #17 when the resident's blood sugar was below the physician prescribed parameter of</p>	F 757	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p style="text-align: center;">F-757</p> <p>It is the intended practice of the facility to ensure that each resident's drug regimen</p>		

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F 757	<p>Continued From page 137 100, on three occasions in February 2019.</p> <p>The findings include:</p> <p>1. Resident # 26 was admitted to the facility on 11/22/2016 with diagnoses that included but were not limited to dementia (1), depressive disorder (2), dysphagia (3) and diabetes mellitus (4).</p> <p>Resident # 26's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/08/19, coded Resident # 26 as scoring a 9 (nine) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 9 (nine)-being moderately impaired of cognition intact for making daily decisions. Resident # 26 was coded as requiring limited assistance of one staff member for activities of daily living.</p> <p>The physician's order sheet (POS) dated February, March, April 2019 for Resident # 26 documented "Novolog (6). Inject 5 units subcutaneously before meals for DM (diabetes mellitus). Hold for BS (blood sugar) &lt; (less than) 150. Order Date: 11/20/2018."</p> <p>The eMAR (electronic medication administration record) dated February 2019 for Resident # 26 documented the above physician's order for Novolog insulin. Further review of the eMAR revealed Novolog was administered on the following dates when the resident's blood sugar was below 150: 02/01/19 with blood sugar of 98, 02/02/19 with blood sugar of 68, 02/05/19 with blood sugar of 129, 02/08/19 with blood sugar of 127, 02/09/19 with blood sugar of 113,</p>	F 757	<p>must be free from unnecessary drugs.</p> <p>1. Resident #26 was audited for blood sugar parameters related to insulin usage. Resident #17 was audited for blood sugar parameters related to insulin usage.</p> <p>2. Residents that are on insulin and reside in the facility have the potential to be affected.</p> <p>3. Licensed Nurses were re-educated on following all prescribers orders to include blood sugar parameters.</p> <p>4. Director of Nursing and/or designee will audit medication administration records and progress notes for 5 residents on insulin daily x 5 days and then 3 days a week x 3 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated.</p> <p>5. The facility alleged date of compliance is June 11, 2019.</p>		

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F 757	<p>Continued From page 138</p> <p>02/11/19 with blood sugar of 85, 02/16/19 with blood sugar of 97, 02/20/19 with blood sugar of 103 and 02/25/19 with blood sugar of 104.</p> <p>The eMAR (electronic medication administration record) dated March 2019 for Resident # 26 documented the above physician's order for Novolog insulin. Further review of the eMAR revealed Novolog was administered when the resident's blood sugar was below 150: On 03/02/19 with blood sugar of 114, 03/03/19 with blood sugar of 93 and 103, 03/05/19 with blood sugar of 136, 03/10/19 with blood sugar of 104, 03/11/19 with blood sugar of 120 and 88, 03/16/19 with blood sugar of 97, 03/17/19 with blood sugar of 91, 03/19/10 with blood sugar of 135, 03/21/19 with blood sugar of 130, 03/25/19 with blood sugar of 11 and 144, 03/29/19 with blood sugar of 140, 03/30/19 with blood sugar of 92 and 03/31/19 with blood sugar of 137.</p> <p>The eMAR (electronic medication administration record) dated April 2019 for Resident # 26 documented the above physicians order for Novolog insulin. Further review of the eMAR revealed Novolog was administered on the following dates when the resident's blood sugar was below 150: 04/05/19 with blood sugar of 112, 04/08/19 with blood sugar of 114, 04/10/19 with blood sugar of 119, 04/12/19 with blood sugar of 98, 04/13/19 with blood sugar of 101, 04/16/19 with blood sugar of 129 and 102, 04/21/19 with blood sugar of 101 and 144,</p>	F 757			

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F 757	<p>Continued From page 139</p> <p>04/22/19 with blood sugar of 95, 04/27/19 with blood sugar of 72, 04/29 with blood sugar of 134 and 04/30/19 with blood sugar of 109.</p> <p>The comprehensive care plan for Resident # 12 dated 11/23/2016 documented, "Focus. Endocrine System related to; insulin Dependent Diabetes." Under "Interventions" it documented, "Administer medication per physician orders. Date Initiated 11/23/2016."</p> <p>On 05/02/19 at 12:38 p.m., an interview was conducted with RN (registered nurse) # 6, unit manager. When asked to describe the check marks on the eMARs, RN # 6 stated, "It means it (insulin) was given." After reviewing Resident # 26's physician's order sheets dated February, March and April 2019 and the eMARS dated February, March and April where the insulin was administered with blood sugars below 150, RN # 6 stated, "The reason there are parameters is to avoid a negative outcomes. Resident has not had negative effects from receiving the insulin with the blood sugar below 150."</p> <p>The facility policy, "Medication Administration: Injections" documented in part, "Procedure: 1. Open MAR to patient record and review medical practitioner medication order against medication label...3. Prepare medications; draw ordered amount of medication into syringe...SUGGESTED DOCUMENTATION: Unusual observation and/or complaints and subsequent interventions including communications with medical practitioner as clinically indicated. Patient refusal of medication and reason with medical practitioner communication for guidance, as necessary."</p>	F 757			

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F 757	Continued From page 140  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."  "INDICATIONS AND USAGE: NOVOLOG is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. WARNINGS AND PRECAUTIONS: .....5.3 Hypoglycemia: Hypoglycemia is the most common adverse effect of all insulin therapies, including NOVOLOG. Severe hypoglycemia can cause seizures, may lead to unconsciousness, may be life threatening or cause death. Hypoglycemia can impair concentration ability and reaction time; this may place an individual and others at risk in situations where these abilities are important (e.g. driving or operating other machinery)." Risk Mitigation Strategies for Hypoglycemia: Patients and caregivers must be educated to recognize and manage hypoglycemia. Self-monitoring of blood glucose plays an essential role in the prevention and management of hypoglycemia .... " This information was obtained from the website: <a href="https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5#i4i_warnings_precautions_id_4bc7c883-0765-44cd-8028-c744ee1c4853">https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5#i4i_warnings_precautions_id_4bc7c883-0765-44cd-8028-c744ee1c4853</a>  On 05/02/19 at approximately 3:30 p.m., ASM (administrative staff member) # 1, the interim administrator and ASM # 2, mobile administrator,	F 757			

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

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 757	<p>Continued From page 141</p> <p>ASM # 3, executive director of the assisted living facility, and ASM # 4, director of nursing were made aware of the findings.</p> <p>No further information was provided prior to exit.</p> <p>References:</p> <p>(1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/000739.htm">https://medlineplus.gov/ency/article/000739.htm</a>.</p> <p>(2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/003213.htm">https://medlineplus.gov/ency/article/003213.htm</a>.</p> <p>(3) A swallowing disorder. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html">https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html</a>.</p> <p>(4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm">https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm</a>.</p> <p>(5) A rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. This information was obtained from the website:</p>	F 757		

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 757	<p>Continued From page 142</p> <p><a href="https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5">https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5</a>.</p> <p>2. The facility staff administered insulin to Resident #17 when the resident's blood sugar was below the physician prescribed parameter of 100, on three occasions in February 2019.</p> <p>Resident #17 was admitted to the facility on 7/27/18, diagnoses included, but are not limited to, diabetes, high blood pressure, atrial fibrillation, dementia with behaviors, depression, and anxiety disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/1/19. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; supervision for transfers, ambulation, dressing, toileting and hygiene; was independent for eating, and was continent of bowel and bladder.</p> <p>A review of the clinical record revealed the following physician orders that were in effect for all or part of February 2019: An order dated 9/4/18 for Lantus (1) 40 units at bedtime. This order was discontinued on 4/18/19. An order dated 2/13/19 for Novolog (2) Flexpen 3 units before meals, hold if blood sugar is below 100. This order was discontinued on 2/27/19.</p> <p>A review of the February 2019 MAR revealed the following:</p> <p>2/14/19 - the morning dose of Novolog 3 units</p>	F 757			

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F 757	<p>Continued From page 143</p> <p>was given. The medication was to be held if the blood sugar was less than 100. The resident's blood sugar was 79. There was no evidence of physician notification that the medication was given when the blood sugar was outside of parameters to give the medication.</p> <p>2/15/19 - the morning dose of Novolog 3 units was given. The medication was to be held if the blood sugar was less than 100. The resident's blood sugar was 89. There was no evidence of physician notification that the medication was given when the blood sugar was outside of parameters to give the medication.</p> <p>2/25/19 - the morning dose of Novolog 3 units was given. The medication was to be held if the blood sugar was less than 100. The resident's blood sugar was 95. There was no evidence of physician notification that the medication was given when the blood sugar was outside of parameters to give the medication.</p> <p>A review of the care plan revealed one dated 7/27/18 for "Endocrine System related to; Insulin Dependent Diabetes." This care plan included the interventions, "Administer medication per physician orders" dated 7/27/18, "Obtain glucometer readings and report abnormalities as ordered" dated 2/12/19, "Obtain Lab results as ordered and notify physician of results" dated 7/27/18.</p> <p>On 5/2/19 at 11:06 AM, an interview was conducted with LPN #1. When asked about the above findings of insulins administered when</p>	F 757			



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F 757	<p>Continued From page 144</p> <p>there were ordered parameters to hold it, LPN #1 stated that it should have been held and the physician should be notified that it was not held. When asked if the care plan documented to administer insulin as ordered and the above errors were made regarding the administration of insulin, was the care plan being followed, LPN #1 stated it was not.</p> <p>On 5/2/19 at 11:20 AM, ASM #1 (Administrative Staff Member) (Administrator), ASM #2 (Mobile Administrator), ASM #3 (ALF Executive Director) and ASM #4 (Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey.</p> <p>(1) Lantus - Insulin glargine is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes. In people with type 1 diabetes, insulin glargine must be used with another type of insulin (a short-acting insulin). In people with type 2 diabetes, insulin glargine also may be used with another type of insulin or with oral medication(s) for diabetes. Insulin glargine is a long-acting, manmade version of human insulin. Insulin glargine works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar.</p>	F 757			

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F 757	Continued From page 145 Information obtained from <a href="https://medlineplus.gov/druginfo/meds/a600027.html">https://medlineplus.gov/druginfo/meds/a600027.html</a>  (2) Novolog - Insulin aspart is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. In patients with type 1 diabetes, insulin aspart is usually used with another type of insulin, unless it is used in an external insulin pump. In patients with type 2 diabetes, insulin aspart also may be used with another type of insulin or with oral medication(s) for diabetes. Insulin aspart is a short-acting, manmade version of human insulin. Insulin aspart works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar. Information obtained from <a href="https://medlineplus.gov/druginfo/meds/a605013.html">https://medlineplus.gov/druginfo/meds/a605013.html</a> Insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar. Information obtained from <a href="https://medlineplus.gov/druginfo/meds/a697021.html">https://medlineplus.gov/druginfo/meds/a697021.html</a>	F 757			
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)  The facility must ensure that its-	F 760		5/23/19	

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F 760	<p>Continued From page 146</p> <p>§483.45(f)(2) Residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined the facility staff failed to ensure three of 56 residents were free from significant medication errors, Residents # 93, #26 and #17.</p> <p>1. The facility staff held Resident #93's prescribed insulin without a physician order on multiple occasions in April 2019.</p> <p>2. The facility staff failed to hold the administration of insulin and administered insulin to Resident # 26's when the resident's blood sugar was below the physician ordered parameter of 150 on multiple dates in February, March and April 2019.</p> <p>3. The facility staff administered insulin to Resident #17 when the residents blood sugar was below the physician prescribed parameter of 100, on three occasions in February 2019, and failed to administer insulin as ordered on multiple occasions in February, March and April 2019.</p> <p>The findings include:</p> <p>1. The facility staff held Resident #93's insulin without a physician order on multiple occasions in April 2019.</p> <p>Resident #93 was admitted to the facility on 8/18/17 with a recent readmission on 3/27/18, with diagnoses that included but were not limited to: dementia, psychosis [major mental disorder in</p>	F 760	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p style="text-align: center;">F-760</p> <p>It is the intended practice of the facility to ensure that residents are free of any significant medication errors.</p> <p>1. Resident #93, #26, and #17 nurse notified the physician of medication errors prior to exit of survey.</p> <p>2. Residents that receive insulin and reside in the facility have the potential to be affected.</p> <p>3. Licensed Nurses were re-educated on following physician orders related to insulin to include blood sugar parameters.</p> <p>4. Director of Nursing and/or designee will audit medication administration records of 5 residents currently on insulin daily x 5 days and then 3 days a week x 3</p>		

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F 760	<p>Continued From page 147</p> <p>which the person is usually detached from reality and has impaired perceptions, thinking, responses and interpersonal relationships (1), diabetes and high blood pressure.</p> <p>The most recent MDS (minimum data set) assessment with an assessment reference date of 4/3/19, coded the resident as scoring a "1" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance for most of his activities of daily living. In Section N - Medications, the resident was coded as receiving five days of insulin injections during the look back period.</p> <p>The physician order dated, 3/27/19, documented, "Insulin Glargine Solution (Lantus) [a long acting insulin used to treat diabetes (2)] inject 10 unit subcutaneously at bedtime for dm (diabetes mellitus)."</p> <p>The April 2019 MAR (medication administration record) documented the above physician order. On the following dates, the MAR documented the medication as not administered as ordered by the physician: 4/5/19 - a "6" was documented. (The code on the MAR for a "6" was "no insulin per order.") - The resident's blood sugar was documented as "97." 4/6/19 - a "6" was documented. The resident's blood sugar was documented as "96." 4/7/19 - a "6" was documented. The resident's blood sugar was documented as "98." 4/14/19 - a "9" was documented. (The code on the MAR for a "9" was "see progress note"). The resident's blood sugar was not documented. 4/16/19 - a "9" was documented. The resident's</p>	F 760	<p>weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicted.</p> <p>5. The facility alleged date of compliance is June 11, 2019.</p>		

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F 760	<p>Continued From page 148</p> <p>blood sugar was not documented. 4/18/19 - a "6" was documented. The resident's blood sugar was documented as "106." 4/22/19 - a "6" was documented. The resident's blood sugar was documented as "68." 4/23/19 - a "6" was documented. The resident's blood sugar was documented as "114." 4/24/19 - a "6" was documented. The resident's blood sugar was documented as "98."</p> <p>Review of the nurse's notes for the month of April failed to evidence any documentation of the reason the insulin was held, physician notification or notification to the responsible party except on 4/16/19 at 11:58 p.m. the nurse documented the reason insulin was held but no notification to the physician, "BS (blood sugar) - 88 Held insulin tonight."</p> <p>The comprehensive care plan dated, 8/18/17, documented in part, "Focus: Insulin therapy to treat DM2 (diabetes mellitus type two). At risk for adverse effects." The "Interventions" documented, "Educate/review current medication, reason for use &amp; (and) administration needs with patient &amp;/or family. Report signs &amp; symptoms of adverse reactions."</p> <p>On 5/2/19 at 9:25 a.m., an interview was conducted with LPN (licensed practical nurse) # 4 (one of the nurse's that held the above ordered insulin). When asked what Lantus is, LPN #4 stated, "Insulin, long acting." When asked if a nurse should ever hold Lantus, LPN #4 stated, "If there are parameters for it depends on what the order says." When asked if there are no parameters, can a nurse hold it, LPN #4 stated, "If there is a question, you can call the doctor and get an order." LPN #4 was asked to review the</p>	F 760			

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

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F 760	<p>Continued From page 149</p> <p>above physician order for Resident #93 and the MAR. When asked why she didn't give the insulin on those dates, LPN #4 stated, "It looks like it (the blood sugar) was under 100 and usually we have orders to hold for less than 100." When asked if she had an order to hold if less than 100, LPN #4 stated, "No, Ma'am." When asked what staff should do when they hold a medication, LPN # 4 stated, "We usually contact the doctor and the responsible party." LPN #4 was asked to review her nurse's notes for the above dates. When asked if she had documentation that she contacted the doctor and responsible party when she held the insulin, LPN #4 stated, "It's not there. I didn't do it."</p> <p>On 5/2/19 at 10:01 a.m., an interview was conducted with LPN #5, (one of the nurse's that held the above ordered insulin). When asked what Lantus is, LPN #5 stated, "Insulin." When asked if it's long acting or short acting insulin, LPN #5 stated, "I believe it's long acting." When asked if a nurse should hold Lantus, LPN #5 stated, "If there are specific parameters on the orders we are supposed to." LPN #5 reviewed the above physician orders for Resident #93, MAR and nurse's notes. When asked if the physician ordered specific parameters for this resident, LPN #5 stated, "No." LPN #5 verified her initials on the MAR. When asked why the insulin was held, LPN #5 stated, "Because his blood sugar was low. I shouldn't have done that. I should have called the doctor. That is my error." When asked if she called the doctor, LPN #5 stated, "No."</p> <p>The facility policy, "Medication Administration: Injections" documented in part, "Procedure: 1. Open MAR to patient record and review medical</p>	F 760			

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F 760	<p>Continued From page 150</p> <p>practitioner medication order against medication label...3. Prepare medications; draw ordered amount of medication into syringe...SUGGESTED DOCUMENTATION: Unusual observation and/or complaints and subsequent interventions including communications with medical practitioner as clinically indicated. Patient refusal of medication and reason with medical practitioner communication for guidance, as necessary."</p> <p>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."</p> <p>ASM (administrative staff member) #2, the mobile administrator, ASM #1, the interim administration, and ASM #3, the assisted living facility executive director, were made aware of the above concern on 5/2/19 at 10.58 a.m.</p> <p>No further information was provided prior to exit.</p> <p>(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 483.</p> <p>(2) This information was obtained from the following website: <a href="https://medlineplus.gov/druginfo/meds/a600027.html">https://medlineplus.gov/druginfo/meds/a600027.html</a>.</p> <p>2. The facility staff failed to hold the administration of insulin and administered insulin</p>	F 760			

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F 760	<p>Continued From page 151 to Resident # 26's when the resident's blood sugar was below the physician ordered parameter of 150 on multiple dates in February, March and April 2019.</p> <p>Resident # 26 was admitted to the facility on 11/22/2016 with diagnoses that included but were not limited to dementia (1), depressive disorder (2), dysphagia (3) and diabetes mellitus (4).</p> <p>Resident # 26's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/08/19, coded Resident # 26 as scoring a 9 (nine) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 9 (nine)-being moderately impaired of cognition intact for making daily decisions. Resident # 26 was coded as requiring limited assistance of one staff member for activities of daily living.</p> <p>The physician's order sheet (POS) dated February, March, April 2019 for Resident # 26 documented "Novolog (6). Inject 5 units subcutaneously before meals for DM (diabetes mellitus). Hold for BS (blood sugar) &lt; (less than) 150. Order Date: 11/20/2018."</p> <p>The eMAR (electronic medication administration record) dated February 2019 for Resident # 26 documented the above physician's order for Novolog insulin. Further review of the eMAR revealed Novolog was administered on the following dates when the resident's blood sugar was below 150: 02/01/19 with blood sugar of 98, 02/02/19 with blood sugar of 68, 02/05/19 with blood sugar of 129, 02/08/19 with blood sugar of 127,</p>	F 760			



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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
(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 760	<p>Continued From page 152</p> <p>02/09/19 with blood sugar of 113, 02/11/19 with blood sugar of 85, 02/16/19 with blood sugar of 97, 02/20/19 with blood sugar of 103 and 02/25/19 with blood sugar of 104.</p> <p>The eMAR (electronic medication administration record) dated March 2019 for Resident # 26 documented the above physician's order for Novolog insulin. Further review of the eMAR revealed Novolog was administered when the resident's blood sugar was below 150: On 03/02/19 with blood sugar of 114, 03/03/19 with blood sugar of 93 and 103, 03/05/19 with blood sugar of 136, 03/10/19 with blood sugar of 104, 03/11/19 with blood sugar of 120 and 88, 03/16/19 with blood sugar of 97, 03/17/19 with blood sugar of 91, 03/19/10 with blood sugar of 135, 03/21/19 with blood sugar of 130, 03/25/19 with blood sugar of 11 and 144, 03/29/19 with blood sugar of 140, 03/30/19 with blood sugar of 92 and 03/31/19 with blood sugar of 137.</p> <p>The eMAR (electronic medication administration record) dated April 2019 for Resident # 26 documented the above physicians order for Novolog insulin. Further review of the eMAR revealed Novolog was administered on the following dates when the resident's blood sugar was below 150: 04/05/19 with blood sugar of 112, 04/08/19 with blood sugar of 114, 04/10/19 with blood sugar of 119, 04/12/19 with blood sugar of 98, 04/13/19 with blood sugar of 101, 04/16/19 with blood sugar of 129 and 102,</p>	F 760			

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F 760	<p>Continued From page 153</p> <p>04/21/19 with blood sugar of 101 and 144, 04/22/19 with blood sugar of 95, 04/27/19 with blood sugar of 72, 04/29 with blood sugar of 134 and 04/30/19 with blood sugar of 109.</p> <p>The comprehensive care plan for Resident # 12 dated 11/23/2016 documented, "Focus. Endocrine System related to; insulin Dependent Diabetes." Under "Interventions" it documented, "Administer medication per physician orders. Date Initiated 11/23/2016."</p> <p>On 05/02/19 at 12:38 p.m., an interview was conducted with RN (registered nurse) # 6, unit manager. When asked to describe the check marks on the eMARs, RN # 6 stated, "It means it (insulin) was given." After reviewing Resident # 26's physician's order sheets dated February, March and April 2019 and the eMARS dated February, March and April where the insulin was administered with blood sugars below 150, RN # 6 stated, "The reason there are parameters is to avoid a negative outcomes. Resident has not had negative effects from receiving the insulin with the blood sugar below 150."</p> <p>The facility policy, "Medication Administration: Injections" documented in part, "Procedure: 1. Open MAR to patient record and review medical practitioner medication order against medication label...3. Prepare medications; draw ordered amount of medication into syringe...SUGGESTED DOCUMENTATION: Unusual observation and/or complaints and subsequent interventions including communications with medical practitioner as clinically indicated. Patient refusal of medication and reason with medical practitioner communication for guidance, as</p>	F 760			

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F 760	<p>Continued From page 154 necessary."</p> <p>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."</p> <p>NOVOLOG- insulin aspart injection, solution: "INDICATIONS AND USAGE: NOVOLOG is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. WARNINGS AND PRECAUTIONS: .....5.3 Hypoglycemia: Hypoglycemia is the most common adverse effect of all insulin therapies, including NOVOLOG. Severe hypoglycemia can cause seizures, may lead to unconsciousness, may be life threatening or cause death. Hypoglycemia can impair concentration ability and reaction time; this may place an individual and others at risk in situations where these abilities are important (e.g. driving or operating other machinery)." Risk Mitigation Strategies for Hypoglycemia: Patients and caregivers must be educated to recognize and manage hypoglycemia. Self-monitoring of blood glucose plays an essential role in the prevention and management of hypoglycemia .... " (7)</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (administrative staff member) # 1, the interim administrator and ASM # 2, mobile administrator, ASM # 3, executive director of the assisted living facility, and ASM # 4, director of nursing were made aware of the findings.</p>	F 760			

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F 760	Continued From page 155  No further information was provided prior to exit.  References: (1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/000739.htm">https://medlineplus.gov/ency/article/000739.htm</a> .  (2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/003213.htm">https://medlineplus.gov/ency/article/003213.htm</a> .  (3) A swallowing disorder. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html">https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html</a> .  (4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm">https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm</a> .  (6) A rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. This information was obtained from the website: <a href="https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5">https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5</a> .	F 760			

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F 760	<p>Continued From page 156</p> <p>(7) This information was obtained from the website: <a href="https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5#i4i_warnings_precautions_id_4bc7c883-0765-44cd-8028-c744ee1c4853">https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5#i4i_warnings_precautions_id_4bc7c883-0765-44cd-8028-c744ee1c4853</a></p> <p>3. The facility staff administered insulin to Resident #17 when the residents blood sugar was below the physician prescribed parameter of 100, on three occasions in February 2019, and failed to administer insulin as ordered on multiple occasions in February, March and April 2019.</p> <p>Resident #17 was admitted to the facility on 7/27/18 with the diagnoses of but not limited to diabetes, high blood pressure, atrial fibrillation, dementia with behaviors, depression, and anxiety disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/1/19. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; supervision for transfers, ambulation, dressing, toileting and hygiene; was independent for eating, and was continent of bowel and bladder.</p> <p>FEBRUARY 2019:</p> <p>A review of the clinical record revealed the following physician orders that were in effect for all or part of February 2019:</p> <p>An order dated 9/4/18 for Lantus (1) 40 units at bedtime. This order was discontinued on</p>	F 760			

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F 760	<p>Continued From page 157 4/18/19.</p> <p>An order dated 2/13/19 for Novolog (2) Flexpen 3 units before meals, hold if blood sugar is below 100. This order was discontinued on 2/27/19.</p> <p>A review of the February 2019 MAR revealed the following:</p> <p>2/14/19 - the morning dose of Novolog 3 units was given. The medication was to be held if the blood sugar was less than 100. The resident's blood sugar was 79. There was no evidence of physician notification that the medication was given when the blood sugar was outside of parameters to give the medication.</p> <p>2/15/19 - the morning dose of Novolog 3 units was given. The medication was to be held if the blood sugar was less than 100. The resident's blood sugar was 89. There was no evidence of physician notification that the medication was given when the blood sugar was outside of parameters to give the medication.</p> <p>2/19/19 - no evidence of the Lantus 40 units being administered at bedtime. The MAR was left blank.</p> <p>2/25/19 - the morning dose of Novolog 3 units was given. The medication was to be held if the blood sugar was less than 100. The resident's blood sugar was 95. There was no evidence of physician notification that the medication was given when the blood sugar was outside of parameters to give the medication.</p>	F 760			

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F 760	<p>Continued From page 158 MARCH 2019:</p> <p>A review of the clinical record revealed the following physician orders that were in effect for all or part of March 2019:</p> <p>An order dated 9/4/18 for Lantus 40 units at bedtime. This order was discontinued on 4/18/19.</p> <p>An order dated 2/27/19 for Humalog (3) 6 units before meals. This order was discontinued on 3/5/19.</p> <p>An order dated 3/5/19 for Novolog 6 units before meals. This order remained active as of the survey.</p> <p>A review of the March 2019 MAR revealed the following:</p> <p>3/4/19 - lunchtime dose of Humalog 6 units was held. There were no orders or parameters to hold the Humalog. The resident's blood sugar was 92. There was no evidence the physician was notified of the Humalog being held when it was not ordered to be held.</p> <p>3/6/19 - the morning Novolog of 6 units was held. There were no orders or parameters to hold the Novolog. The resident's blood sugar was 83. There was no evidence the physician was notified of the Novolog being held when it was not ordered to be held.</p> <p>3/10/19 - the morning Novolog of 6 units was held. There were no orders or parameters to hold the Novolog. The resident's blood sugar</p>	F 760			

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F 760	<p>Continued From page 159</p> <p>was 95. There was no evidence the physician was notified of the Novolog being held when it was not ordered to be held.</p> <p>3/10/19 - no evidence of the Lantus 40 units being administered at bedtime. The MAR was left blank.</p> <p>3/15/19 - the morning Novolog of 6 units was held. There were no orders or parameters to hold the Novolog. The MAR was coded as "Other/See Nurse Notes." The notes documented the blood sugar was 79. There was no evidence the physician was notified of the Novolog being held when it was not ordered to be held.</p> <p>3/17/19 - no evidence of the Lantus 40 units being administered at bedtime. The MAR was left blank.</p> <p>3/27/19 - no evidence of the Lantus 40 units being administered at bedtime. The MAR was coded as "Other/See Nurse Notes." The notes documented the blood sugar was 72 and rechecked to be 80. There were no orders to hold the Lantus. There was no evidence the physician or nurse practitioner was notified of the medication being held.</p> <p>APRIL 2019:</p> <p>A review of the clinical record revealed the following physician orders that were in effect for all or part of March 2019:</p> <p>An order dated 9/4/18 for Lantus 40 units at bedtime. This order was discontinued on</p>	F 760			



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F 760	<p>Continued From page 160 4/18/19.</p> <p>An order dated 3/5/19 for Novolog 6 units before meals. This order remained active as of the survey.</p> <p>A review of the April 2019 MAR revealed the following:</p> <p>4/2/19 - no evidence of the lunchtime Novolog 6 units being administered. The MAR was left blank.</p> <p>4/3/19 - no evidence of the Lantus 40 units being administered at bedtime. The MAR was left blank.</p> <p>4/3/19 - the morning dose of Novolog 6 units was held. The blood sugar was 117. There were no orders or parameters to hold the Novolog. There was no evidence the physician was notified of the Novolog being held when it was not ordered to be held.</p> <p>4/3/19 - the lunchtime dose of Novolog 6 units was held. There was no documented blood sugar. There were no orders or parameters to hold the Novolog. There was no evidence the physician was notified of the Novolog being held when it was not ordered to be held.</p> <p>4/11/19 - the lunchtime dose of Novolog 6 units was held. The blood sugar was 99. There were no orders or parameters to hold the Novolog. There was no evidence the physician was notified of the Novolog being held when it was not ordered to be held.</p>	F 760			

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F 760	Continued From page 161  A review of the care plan revealed one dated 7/27/18 for "Endocrine System related to; Insulin Dependent Diabetes." This care plan included the interventions, "Administer medication per physician orders" dated 7/27/18, "Obtain glucometer readings and report abnormalities as ordered" dated 2/12/19, "Obtain Lab results as ordered and notify physician of results" dated 7/27/18.  On 5/2/19 at 11:06 AM, an interview was conducted with LPN #1. LPN #1 was asked about the above findings of insulins being held when there was no parameters or orders to hold it. LPN #1 stated that it should have been administered and if the nurse felt it was not safe to do so, she should notify the physician of the blood sugar and see if the physician wants to hold the dose and write the order for it. She stated a nurse cannot hold a medication without an order. When asked about the above findings of insulins administered when there were ordered parameters to hold it, LPN #1 stated that it should have been held and the physician should be notified that it was not held. When asked about the above findings of insulins not being documented at all as being administered when they should be, LPN #1 stated that there is no way to know if it was done or not, so if it wasn't documented, it wasn't done. She stated that the computer system the facility uses is difficult to understand and that it needs to be clearer for nurses to understand. She stated the system provides options to select if a medication was given, held, refused, etc. She stated that blood sugars are hard to monitor on the computer. When asked if the care plan documented to administer insulin as ordered, and the above	F 760			

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F 760	<p>Continued From page 162</p> <p>errors were made regarding the administration of insulin, then was the care plan followed, LPN #1 stated it was not.</p> <p>On 5/2/19 at 11:20 AM, ASM #1 (Administrative Staff Member) (Administrator), ASM #2 (Mobile Administrator), ASM #3 (ALF Executive Director) and ASM #4 (Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey.</p> <p>(1) Lantus - Insulin glargine is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes. In people with type 1 diabetes, insulin glargine must be used with another type of insulin (a short-acting insulin). In people with type 2 diabetes, insulin glargine also may be used with another type of insulin or with oral medication(s) for diabetes. Insulin glargine is a long-acting, manmade version of human insulin. Insulin glargine works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar. Information obtained from <a href="https://medlineplus.gov/druginfo/meds/a600027.html">https://medlineplus.gov/druginfo/meds/a600027.html</a></p> <p>(2) Novolog - Insulin aspart is used to treat type 1 diabetes (condition in which the body does not</p>	F 760			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/02/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 760	<p>Continued From page 163</p> <p>produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. In patients with type 1 diabetes, insulin aspart is usually used with another type of insulin, unless it is used in an external insulin pump. In patients with type 2 diabetes, insulin aspart also may be used with another type of insulin or with oral medication(s) for diabetes. Insulin aspart is a short-acting, manmade version of human insulin. Insulin aspart works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar.</p> <p>Information obtained from <a href="https://medlineplus.gov/druginfo/meds/a605013.html">https://medlineplus.gov/druginfo/meds/a605013.html</a></p> <p>(3) Humalog - Insulin lispro is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. In patients with type 1 diabetes, insulin lispro is always used with another type of insulin, unless it is used in an external insulin pump. In patients with type 2 diabetes, insulin lispro may be used with another type of insulin or with oral medication(s) for diabetes. Insulin lispro is a short-acting, manmade version of human insulin. Insulin lispro works by replacing the insulin that is normally produced by the body and by helping</p>	F 760			

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F 760	Continued From page 164 move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar. Information obtained from <a href="https://medlineplus.gov/druginfo/meds/a697021.html">https://medlineplus.gov/druginfo/meds/a697021.html</a>	F 760			
F 772 SS=D	Lab Services Not Provided On-Site CFR(s): 483.50(a)(1)(iv)  §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined the facility staff failed to ensure that expired laboratory supplies were not available for resident use in one of three medication supply rooms inspected.  The facility staff failed to ensure that expired laboratory supplies were not available for resident use in the 600 Unit medication supply room.  The findings include:  On 5/1/19 at 1:32 PM an inspection was conducted of Unit #600's medication supply room. The inspection of Unit #600's medication supply room revealed that two Universal Viral Transport Media and Swabs (1), with an	F 772		5/23/19	
			The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.  F-772 It is the intended practice of the facility to ensure that expired laboratory supplies are not available for resident use.		

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F 772	<p>Continued From page 165</p> <p>expiration date of 12/2018 were in the laboratory collection basket and available for resident use.</p> <p>On 5/1/19 at 1:45 PM an interview was conducted with LPN (Licensed Practical Nurse) #3. LPN #3 was asked about the process staff follows for the maintenance of the medication room. LPN #3 stated, "The medical supply personnel clean the room nightly." When LPN #3 was asked about the process for expired items, LPN #3 stated, "The expired items are removed and not stored in the medication room."</p> <p>On 5/1/19 at 1:38 PM an interview was conducted with LPN #2. When LPN #2 was asked if expired laboratory supplies in the medication supply room could be used for residents'. LPN #2 stated, "If it is in the bucket and they grab it, they could use it on a resident. But that is not what I do. I check the dates before I use anything."</p> <p>A review of the facility's policy "Storage and Expiration Dating of Drugs, Biologicals, Syringes, and Needles with a revision date of 8/2018 documented in part, " ...Procedure ...Have not been retained longer than recommended by manufacturer or supplier guidelines ...Nursing Center personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis ..."</p> <p>On 5/2/19 at 4:02 PM, ASM (Administrative Staff Member) #1 (Interim Administrator), ASM #2 (Mobile Administrator), ASM #4 (Director of Nursing), and ASM #3 (Education Department) were made aware of the findings.</p> <p>According to applicable requirements for laboratories specified in Part 493 of this chapter:</p>	F 772	<ol style="list-style-type: none"> <li>1. Upon notification from surveyor, expired laboratory supplies were removed and discarded immediately from medication supply room.</li> <li>2. Residents that reside in the facility have the potential to be affected.</li> <li>3. Licensed Nurses were re-educated on ensuring expired lab supplies are not available for resident use.</li> <li>4. Director of Nursing and/or designee will audit medication rooms to ensure expired laboratory supplies are not available for resident use daily x 5 days and then 3 days a week x 3 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated.</li> <li>5. The facility alleged date of compliance is June 11, 2019.</li> </ol>		

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F 772	Continued From page 166 § 493.1252 Standard: Test systems, equipment, instruments, reagents, materials, and supplies.(4) (d) Reagents, solutions, culture media, control materials, calibration materials, and other supplies must not be used when they have exceeded their expiration date, have deteriorated, or are of substandard quality.  No further information was provided by the end of the survey.  (1) Universal Viral Transport Media and Swabs: Culture Swabs provide a safe and sterile environment for applicators to be transported in. Culture Swabs include housing for individual swabs to ensure that the swab's specimen is free of contamination. Culture Swabs are available in both wet and dry swabs. This information was obtained from the website: <a href="https://www.quickmedical.com/culture-swabs.html">https://www.quickmedical.com/culture-swabs.html</a>	F 772			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)  §483.60(i) Food safety requirements. The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		5/23/19	

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F 812	<p>Continued From page 167 from consuming foods not procured by the facility.</p> <p>§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:</p> <p>Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store and prepare food in accordance with professional standards of food service safety.</p> <ol style="list-style-type: none"> <li>The facility staff failed to ensure food was discarded on before the expiration date.</li> <li>The facility staff failed to ensure hair was covered in the food preparation area.</li> </ol> <p>The findings included:</p> <ol style="list-style-type: none"> <li>The facility staff failed to ensure food was discarded on before the expiration date.</li> </ol> <p>On 4/30/19 at approximately 11:05 a.m., an observation was made of the dry storage room in the kitchen with OSM (other staff member) #4, the Food Service Manager. An observation was made of an opened bag of cereal with a hand written expiration sticker dated 3/23/19.</p> <p>On 4/30/19 at approximately 11:07 a.m., an observation was made of the reach in refrigerator in the kitchen with OSM #4, the Food Service Manager. Four cartons of fat free skim milk dated 4/23/19 was found to be past the expiration date.</p> <p>On 4/30/19 at approximately 11:10 a.m., an</p>	F 812	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p style="text-align: center;">F-812</p> <p>It is the intended practice of the facility to store and prepare food in accordance with professional standards of food service safety.</p> <ol style="list-style-type: none"> <li>Upon notification of surveyor, facility staff immediately disposed of expired food items and hair and beards were immediately covered.</li> <li>Residents that reside in the facility have the potential to be affected.</li> <li>Dietary staff were educated on safe and sanitary practices.</li> <li>Food Service Director and/or designee will audit food service area for expired</li> </ol>		



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F 812	<p>Continued From page 168</p> <p>observation was made of the walk in refrigerator in the kitchen with OSM #4, the Food Service Manager. Multiple cartons of fat free skim milk were found to be past the expiration date, all were dated, 4/23/2019.</p> <p>On 4/30/19 at approximately 11:15 a.m., an interview was conducted with OSM #4. When asked how open dry food should be stored. OSM #4 replied, "When we open something we put a hand written sticker telling us when we should throw it out. We keep dry food for a month after it's been opened or we throw it away on the manufacturer's expiration date. When asked if the bag of cereal should have been thrown away, OSM #4 replied "Yes." When asked how milk should be stored, OSM #4 replied, "We usually check the expiration date before we put it in the reach in refrigerator. For some reason we didn't do that. It's my responsibility it should have been done. We got a new shipment of milk today and the milk deliveryman usually removes the milk that is past the expiration date and gives us a fresh shipment. He must have brought us expired milk. I have the receipt; I can bring it to you if you want to see it."</p> <p>On 5/1/19 at approximately 3:05 p.m., this surveyor was presented with an invoice dated 4/30/19. The invoice documented the facility received a shipment of fat free skim milk on 4/30/19.</p> <p>Review of the facility policy titled, "Kitchen Sanitation Quick Checklist" dated June 2015 documented, "All foods covered, labeled and dated, out of date items discarded."</p> <p>On 05/02/19 at approximately 1:00 p.m., ASM</p>	F 812	<p>food. Food Service Director and/or designee will audit food services staff on safe sanitary practices to include proper hair practices daily x 5 days and then 3 days a week x 3 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated.</p> <p>5. The facility alleged date of compliance is June 11, 2019.</p>		

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F 812	<p>Continued From page 169</p> <p>(administrative staff member) #1, the Interim Administrator, ASM #2, the Mobile Administrator and ASM #3, the Assisted Living Facility (ALF) Executive Director were made aware of the findings.</p> <p>No further information was obtained prior to exit.</p> <p>2. The facility staff failed to ensure hair was covered in the food preparation area</p> <p>On 4/30/19 at approximately 11:35 a.m., an observation was made of tray line in the kitchen with OSM (other staff member) #4, the Food Service Director. OSM #7, dietary manager, was observed with a hair net that covered the crown of her head but left the sides and the fringes of her hair uncovered. OSM #6, dietary aide, was observed to have a beard that was unrestrained.</p> <p>On 4/30/19 at approximately 12:35 a.m., an interview was conducted with OSM #4. When asked if all hair is supposed to be covered by a hair net, OSM # 4 replied, "The hair, including beards, should be completely covered." When asked why should hair be restrained in the kitchen. OSM #4 replied, "It's an infection control issue."</p> <p>Review of the facility policy titled, "Hair Restraints" dated January 2015 documented, "Hair restraints are worn to keep hair away from food and to minimize touching or handling of hair during food production. Hair is considered to be a foreign object and hair restraints help to avoid hair from falling into food. Hair restraints include: clean hats that cover all hair such as caps and chef's hats, hair covering such as fine nets and</p>	F 812			

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F 812	Continued From page 170 surgical caps, beard or facial hair coverings. Hair restraints are worn in a manner that covers all hair including bangs and pony tails."  On 05/02/19 at approximately 1:00 p.m., ASM (administrative staff member) #1, the Interim Administrator, ASM #2, the Mobile Administrator and ASM #3, the Assisted Living Facility (ALF) Executive Director were made aware of the findings.	F 812			
F 814 SS=C	No further information was obtained prior to exit. Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4)  §483.60(i)(4)- Dispose of garbage and refuse properly. 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 dispose of garbage and refuse properly.  The facility staff failed to ensure the ground around the dumpster's were free from garbage.  The findings included:  On 4/30/19 at approximately 1:05 p.m., an observation was made of the dumpster with OSM (other staff member) #4, the Food Service Manager. On the ground surrounding the dumpster to the left were approximately five medical grade gloves and behind the dumpster was an empty cardboard box.  On 5/1/19 at approximately 2:15 p.m., an	F 814	The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.  F-814  It is the intended practice of the facility to dispose of garbage and refuse properly.  1. Upon notification by surveyor, the trash	5/23/19	

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F 814	Continued From page 171 interview was conducted with OHM #4. When asked who is in charge of ensuring garbage and refuse are disposed of properly. OSM #4 replied, "Maintenance helps but dietary is responsible." When asked how the dumpster is to be maintained, OSM #4 replied, "There is not supposed to be any trash around them and the doors of the dumpster's are supposed to be closed."  Review of the facility policy titled, "Kitchen Sanitation Quick Checklist" dated June 2015 documented, "Dumpster: closed, no trash laying around."  On 05/02/19 at approximately 1:00 p.m., ASM (administrative staff member) #1, the Interim Administrator, ASM #2, the Mobile Administrator and ASM #3, the Assisted Living Facility (ALF) Executive Director were made aware of the findings.  No further information was obtained prior to exit.	F 814	around the dumpster was immediately removed.  2. The residents that reside in the facility have the potential to be affected.  3. Facility staff will be educated that ground around the dumpster should be free of garbage.  4. Housekeeping Director and/or designee will audit the areas around the dumpsters to ensure the area is free from garbage daily x 5 days and then 3 days a week x 3 weeks an then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated.  5. The facility alleged date of compliance is June 11, 2019.		
F 849 SS=E	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 resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.	F 849		5/23/19	

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F 849	Continued From page 172  §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. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate	F 849			

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

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F 849	Continued From page 173 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 administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the	F 849			

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F 849	<p>Continued From page 174</p> <p>hospice and the LTC facility to provide bereavement services to LTC facility staff.</p> <p>§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.</p> <p>The designated interdisciplinary team member is responsible for the following:</p> <p>(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.</p> <p>(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.</p> <p>(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.</p> <p>(iv) Obtaining the following information from the hospice:</p> <p>(A) The most recent hospice plan of care specific to each patient.</p> <p>(B) Hospice election form.</p>	F 849			

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F 849	<p>Continued From page 175</p> <p>(C) Physician certification and recertification of the terminal illness specific to each patient.</p> <p>(D) Names and contact information for hospice personnel involved in hospice care of each patient.</p> <p>(E) Instructions on how to access the hospice's 24-hour on-call system.</p> <p>(F) Hospice medication information specific to each patient.</p> <p>(G) Hospice physician and attending physician (if any) orders specific to each patient.</p> <p>(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.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and clinical record review, it was determined that the facility staff failed to provide comprehensive hospice services for one of 65 residents in the survey sample, Resident # 89.</p> <p>The facility staff failed to evidence consistent communication and collaboration for resident # 89's hospice care.</p> <p>The findings include:</p>	F 849	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p>		



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F 849	<p>Continued From page 176</p> <p>Resident # 89 was admitted to the facility on 08/16/2018 with diagnoses that included but were not limited to benign prostatic hyperplasia (1), Parkinson's disease (2), and hypertension (3).</p> <p>Resident # 89's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/29/2019, coded Resident # 89 as scoring a 3 (three) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions. Resident # 89 was coded as requiring extensive assistance of one staff member for activities of daily living. Section O "Special Treatments, Procedures and Programs" coded Resident # 89 as "K. Hospice Care."</p> <p>The POS (physician's order sheet) dated 03/31/2019 for Resident # 89 documented, "Admit to (Name of Hospice). Order Date: 03/18/2019."</p> <p>The comprehensive care plan for Resident # 89 documented, "Focus: Hospice/Palliative care. Date Initiated: 04/04/2019." Under "Interventions" it documented, "Administer medication per physician orders. Allow patient/family to discuss feelings, etc. Assist patient or surrogate to make advanced directive choices as needed. Date Initiated: 04/04/2019; Honor advance directive. Date Initiated: 04/04/2019; Hospice staff to visit to provide care, assistance, and/or evaluation. Date Initiated: 04/04/2019." Further review of the comprehensive care plan for Resident # 89 documented, "Focus: Pain evidenced by verbalization of pain related to knee pain/osteoarthritis. Date Initiated: 08/17/2018." Under "Interventions" it documented, "Report GI</p>	F 849	<p>F-849</p> <p>It is the intended practice of the facility to ensure that evidence of consistent communication and collaboration for comprehensive resident hospice services.</p> <ol style="list-style-type: none"> <li>1. Resident #89 hospice evaluation and progress notes were placed in the resident's chart prior to the exit of the survey team.</li> <li>2. Residents who are being followed by hospice services and reside in the facility have the potential to be affected.</li> <li>3. Licensed Nurses and the Interdisciplinary Team (IDT) were re-educated on the collaboration with hospice care services in accordance with professional standards.</li> <li>4. Director of Nursing and/or designee will audit hospice residents for hospice evaluations and progress notes. These audits will be completed daily x 5 days then 3 days per week x 3 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated.</li> <li>5. The facility alleges compliance on June 11, 2019.</li> </ol>		

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F 849	<p>Continued From page 177</p> <p>(gastro-intestinal) distress secondary to analgesia such [sic] nausea, constipation, diarrhea. Date Initiated: 08/17/2018; Report nonverbal expressions of pain as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc. Date Initiated: 08/17/2018: Administer pain medication per physician order. Date Initiated: 08/17/2019, Encourage/assist to reposition frequently to position of comfort. Date Initiated: 08/17/2018, Notify physician if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective. Date Initiated: 08/17/2018."</p> <p>Review of the clinical record and the EHR (electronic health record) for Resident # 89 failed to evidence the "(Name of Hospice) Nursing Comprehensive Admission Assessment, (Name of Hospice) Interdisciplinary Plan of Care, (Name of Hospice) Nursing Clinical Notes and (Name of Hospice) Hospice Aide Visit Notes."</p> <p>Review of the facility's nursing "Progress Notes" for Resident # 89 dated 03/18/19 through 05/01/19 failed to evidence documentation of visits from (Name of Hospice) nurse.</p> <p>On 05/01/19 at 10:18 a.m., a requested was made to RN (registered nurse) # 6, unit manager on station six, for the hospice notes, hospice initial evaluation and hospice care plan for Resident # 89. RN # 6 reviewed Resident # 89's clinical record and stated that she does not have them in his clinical record and she would call (Name of Hospice) regarding the notes and have them faxed to the facility. When asked if the hospice notes should be a part of the Resident # 89's clinical record, RN # 6 stated, "I would think so." When asked how the hospice nurse informs</p>	F 849			

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F 849	<p>Continued From page 178</p> <p>the staff of Resident # 89's hospice care, RN # 6 stated, "I'm usually here when the hospice nurse comes here and she will let me know if there are any changes or any new orders. If I'm not available she will tell the charge nurse."</p> <p>On 05/01/19 at 1:50 p.m., a telephone interview was conducted with the OHM (other staff member) # 11, (Name of Hospice) nurse and OHM # 10, (Name of Hospice) secretary. When asked to describe how the hospice documentation is provided to the facility for Resident # 89, OSM # 10 stated, "The notes are printed every two weeks and they are given to the nurse to bring them to the facility on their next visit." When asked about Resident # 89's missing evaluation from hospice and the hospice nurses notes, OSM # 11 stated, "They should have the evaluation and notes. The hospice nurse and the nurse at the facility talk at each visit but there should be note from each visit." During the interview with OSM # 10 and OSM # 11, RN # 6 reviewed Resident # 89's clinical record for the hospice documentation. RN # 6 stated that she was unable to locate any of the hospice documentation for Resident # 89 and this was conveyed to OSM #10 and #11. OSM # 11 then stated that she would fax the hospice documentation for Resident # 89 to the facility and then requested to speak to RN # 6 to obtain the facility's fax number.</p> <p>On 05/01/19 at 2:20 p.m., ASM (administrative staff member) # 2, mobile administrator, provided this surveyor with a three ring binder that documented, "(Name of Hospice) for (Resident # 89)." When asked where the binder came from ASM # 2 stated that RN # 6 would explain and that she was just informed to give it to this</p>	F 849			

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F 849	<p>Continued From page 179 surveyor.</p> <p>On 05/01/19 at approximately 2:22 p.m., a brief interview was conducted with RN # 6. When asked where the (Name of Hospice) binder for Resident # 89 came from, RN # 6 stated, "Hospice dropped off the binder at the front desk."</p> <p>Review of the (Name of Hospice) binder for Resident # 89 revealed the following:                      "(Name of Hospice) Nursing Comprehensive Admission Assessment" dated 03/18/19,                      "(Name of Hospice) Interdisciplinary Plan of Care" dated 03/18/19,                      "(Name of Hospice) Nursing Clinical Notes" dated 03/20/19 through 04/20/19 and                      "(Name of Hospice) Hospice Aide Visit Notes" dated 03/20/19 through 04/24/19.</p> <p>On 05/02/19 at 11:56 a.m., an interview was conducted with RN # 6 regarding the continuity of care and collaboration of Resident # 89's hospice care. When asked how often Resident # 89 is visited by the hospice nurse, RN # 6 stated, "Once a week." When asked if the statement she made the previous day regarding the communication with the hospice nurse, "When the hospice nurse is here she will verbally tell me of any changes with resident before she leave or the charge nurse if I'm not available" was an accurate account, RN # 6 stated "Yes." When asked if verbal communication once a week and not having weekly documentation from hospice provide comprehensive communication and collaboration for Resident # 89's hospice care, RN # 6 stated, "No, It's not comprehensive communication or collaboration." When asked how effective continued communication and</p>	F 849			

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F 849	<p>Continued From page 180</p> <p>collaboration could be established when there was missing hospice notes, RN # 6 stated, "We would have to call them weekly." After reviewing Resident # 89's comprehensive care plan, RN #6 was asked if the care plan identified non-pharmacological interventions to address Resident # 89's pain. RN # 6 stated, "Yes, to reposition frequently to position of comfort." When asked if that was the only intervention that was being used by staff to address Resident # 89's pain, RN # 6 stated, "He also has a stuffed dog that he likes that provides comfort for him and he likes watching others so we bring him out to the nurse's station. These are diversionary activities." When asked if these interventions should be a part of the comprehensive care plan for Resident # 89, RN # 6 stated, "Yes." When asked if his care plan is comprehensive for pain, RN # 6 stated, "No." When asked if Resident # 89 has had a care plan meeting since his admission to hospice care and if the nurse from (Name of Hospice) had attended the care plan meeting, RN # 6 stated, "Yes on April 16 and no the hospice nurse was not there." When asked if the hospice nurse should be involved in the Resident # 89's care plan review meeting to maintain the continuity of care, RN # 6 stated, "Yes." When asked why it was important for the hospice nurse to be involved in attending the care plan meetings, RN # 6 stated, "Because they have the primary, care and ordered medications for the resident and the rapport with the family and they can provide a complete picture of the resident's care."</p> <p>When asked about information in the three ring binder that documented, "(Name of Hospice) for (Resident # 89)" that was provided to this surveyor on 05/01/19 at 2:20 p.m., RN # 6 stated,</p>	F 849			

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F 849	<p>Continued From page 181</p> <p>It contained, the hospice care plan, nurse and nurse aide notes." When asked if that documentation was in the facility, RN # 6 stated, "No. It was not available prior to it being provide dropped off." RN #6 was asked to describe the information and process required to establish the continuity of care and collaboration with hospice services. RN # 6 stated, "The hospice nurse does communicate when they visit and it would be given to the charge nurse and a note would be made by the facility nurse that the hospice nurse was in to visit and it would document any changes of condition would be noted, any new meds (medications) and/or any changes in orders. That information would then be communicated to other staff, the on-coming facility nurses." When asked if this this process was being followed for Resident # 89, RN # 6 reviewed the hospice notes and the facility progress notes and stated, "No." After reviewing the hospice documentation for Resident # 89, RN # 6 was asked if she had the names and contact information for the hospice personnel involved in hospice care of Resident # 89. RN # 6 stated, "No." When asked if she had instructions on how to access the hospice's 24-hour on-call system, RN # 6 stated, "No, I just have the main contact number."</p> <p>The "Nursing Facility Agreement" with the (Name of Hospice) dated "January 1, 2016" documented, "Term and Renewal. The initial term of this agreement is one year and it begins on the date of this Agreement. This agreement will renew automatically for additional one year terms unless terminated pursuant to section 12." Under "4.8 Plan of Care" it documented, "Hospice will collaborate with Facility on a coordinated Plan of Care developed jointly between Hospice and</p>	F 849			

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F 849	Continued From page 182 Facility. Each Hospice Patient's written Plan of Care must include both the most recent Hospice Plan of Care and a description of the services furnished by Facility to attain or maintain the Hospice Patient's highest practicable physical, mental, and psychosocial well-being. Facility will perform all services described in this Agreement in accordance with Facility's protocols, policies and procedures to the extent they are consistent with Hospice protocols, policies and procedure, and Hospice's Plan of Care for each Hospice Patient. Facility agrees to abide by patient care protocols for palliative medicine established by Hospice and to collaborate with the Hospice Interdisciplinary Team prior to decisions for treatment or diagnostic procedures." Under "4.9 Resident Chart" it documented, "Facility and Hospice will prepare and maintain complete medical records for Hospice Patients receiving Facility services in accordance with this Agreement and will include all treatments, progress notes, authorizations, physician orders and other pertinent information. Copies of all documents of services provided by Hospice will be filed and maintained in the Facility chart. Facility will provide Hospice with a copy of the clinical record upon request. Originals of all documents for services provided by Hospices will be filed and maintained by Hospice at the Hospice office. Facility and Hospice will each have access to the Hospice Patient's records maintained by the other party for verification of patient care and financial information pertinent to the Agreement. Access to Hospice Patient's records will be provided during routine hours of business and each party will give reasonable notice to the other of its intent to review such records."	F 849			

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F 849	Continued From page 183 On 05/02/19 at approximately 3:30 p.m., ASM (administrative staff member) # 1, the interim administrator and ASM # 2, mobile administrator, ASM # 3, executive director of the assisted living facility, and ASM # 4, director of nursing were made aware of the findings.  No further information was provided prior to exit.  References: (1) An enlarged prostate. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html">https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html</a> .  (2) High blood pressure. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/highbloodpressure.html">https://www.nlm.nih.gov/medlineplus/highbloodpressure.html</a> .  (3) A type of movement disorder. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html">https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html</a> .	F 849			
F 880 SS=E	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	F 880		5/23/19	



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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 880	<p>Continued From page 184 and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed</p>	F 880			

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F 880	<p>Continued From page 185 by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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 the facility staff failed to follow infection control practices for two of 56 residents in the survey sample, Residents # 65 and # 127 and during dining observations in two of two dining facility dining rooms, (main dining room and Arcadia dining room).</p> <p>1. The facility staff failed to implement infection control practices during Resident # 65's wound care.</p> <p>2. The facility staff failed to keep their thumbs off the food surface of dinner plates and refrain from touching resident's dinner rolls with bare hands while serving the resident's lunch in the main dining room.</p> <p>3a. The facility staff failed to follow infection control practice for the care of Resident #127's respiratory equipment, Resident #127's nasal cannula was observed directly on the floor during</p>	F 880	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>F-880</p> <p>It is the intended practice of the facility to 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.</p>		

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F 880	<p>Continued From page 186 separate observation.</p> <p>3b. The facility staff failed to follow infection control practice for the care of Resident's #127 indwelling urinary catheter collection bag.</p> <p>4. The facility staff failed to wash or sanitize their hands after touching the food service cart, and then touched the edge of resident's plate, and the ice surface of the ice scoop while serving foods and drinks during a lunch observation in the main dining room.</p> <p>5. The facility staff failed to wash or sanitize their hands after touching the food service cart, and then touched the edge of residents' plate, while serving food in the Arcadia dining room during a lunch dining observation.</p> <p>The findings include:</p> <p>1. The facility staff failed to implement infection control practices during Resident # 65's wound care.</p> <p>Resident # 65 was admitted to the facility on 01/13/11 with diagnoses that included but were not limited to Alzheimer's disease (1), diabetes mellitus, (2), hypertension (3) and depressive disorder (4).</p> <p>Resident # 65's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/12/19, failed to coded Resident # 65 on the brief interview for mental status (BIMS). Resident # 65 was coded as being totally dependent of one staff member for activities of daily living. Section M "Skin Conditions)" coded Resident # 65 as having a</p>	F 880	<p>1. Upon notification of surveyor, Resident #65 dressing had been changed since observation of surveyor. Wound care nurse was re-educated on the non-sterile wound care process to include the use of barriers and infection control. Resident #127 had their oxygen tubing and foley bag changed prior to exit of survey team.</p> <p>2. Residents who reside in the facility have the potential to be affected.</p> <p>3. Licensed Nurses were re-educated on infection control practices during wound care including use of barriers. Nursing staff were educated on infection control on foley and oxygen tubing not touching the floor. Facility staff were educated on proper infection control practices to include:</p> <ul style="list-style-type: none"> <li>a. not placing thumb on top surface of plate</li> <li>b. not touching food with a bare hand</li> <li>c. wash and sanitize hands before touching plate</li> <li>d. serve ice without touching the ice surface of the scoop</li> </ul> <p>4. Director of Nursing and/or designee will audit residents on oxygen and residents with foley catheters for tubing not touching the floor daily x 5 days and then 3 days a week x 3 weeks and then monthly x 2 months. Director of Nursing and/or designee will audit 2 residents with pressure ulcers for non-sterile wound care to include use of barriers. This audit will be done daily x 5 days and then 3 days a</p>		

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F 880	<p>Continued From page 187</p> <p>"Stage 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of the tissue loss. May include undermining and tunneling." Under "M1200 Skin and Ulcer/Injury Treatment" it documented, "Pressure ulcer/injury care." The annual MDS assessment with an ARD (assessment reference date) of 12/12/18 coded Resident # 65 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions.</p> <p>On 05/02/19 at approximately 8:50 a.m., an observation was conducted of RN (registered nurse) # 8, the wound care nurse, performing a dressing change on Resident # 65's right heel. Resident # 65 was lying in his bed; RN # 8 assessed Resident # 65 for pain and set up a clean barrier sheet over Resident # 65's over-the-bed-table after disinfecting it. RN # 8 then placed the clean dressings and treatments on the over-the-bed-table. After donning a clean pair of gloves, RN # 8 removed the Prevalon (5) boot from Resident # 65's right foot and placed it under his calf, then removed the old gauze wrapped around Resident # 65 ankle and heel. When attempting to remove the foam bandage covering the heel, Resident # 65 yelled in pain, RN # 8 immediately stopped the process, asked Resident # 65 if it hurt, Resident # 65 stated yes. RN # 8 then obtained a vile of normal saline, informed Resident # 65 the he would apply the saline over the wound and the bandage to loosen the adhesive from his skin. Without pacing a clean barrier under Resident # 65's right foot/heel, RN #8 poured the saline over the wound and bandage and slowly removed the</p>	F 880	<p>week x 3 weeks and then monthly x 2 months. Food Service Director and/or designee will audit dining services to ensure staff are not placing thumb on top surface of plate, not touching food with a bare hand, wash and sanitize hands before touching plates, and serve ice without touching the surface of the scoop daily x 5 days and then 3 days a week x 3 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated.</p> <p>5. The facility alleged date of compliance is June 11, 2019.</p>		

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

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F 880	<p>Continued From page 188</p> <p>bandage from Resident # 65's heel. Observation of this process revealed the saline running over the heel wound and old bandage and running on to Resident # 65's fitted sheet that was over his mattress. When the bandage was removed, RN # 8 was asked to describe the wound. RN # 8 stated, "It measured 4.2 millimeters long and 4.3 millimeters wide, 40% granulation tissue, small amount of drainage, no odor, painful to the touch, and 60 % epithelial." Observation of the bed sheet under Resident # 65's right heel revealed the area was soaked from the saline poured over the open wound and contained a small amount a blood. After taking the wound measurements, RN # 8 placed Resident # 65's right heel directly on the wet area on the mattress where the wound was rinsed. RN # 8 then cleaned the wound with a clean four-by-four gauze with clean saline, placed the heel back on the wet area on the bed, retrieved the treatment, medihoney (6) from the over-the-bed-table, applied it to the wound, placed the residents heel back in the same position on the bed, retrieved a clean dressings and wrapped the wound. RN # 8 placed Resident # 65's right foot back into the Prevalon boot placed it on the wet area on the bed and covered Resident # 65's legs with a blanket. Further observation failed to evidence RN # 8 changing the fitted sheet on Resident # 65's bed or requesting that a CNA (certified nursing assistant) or a another nurse change it, and left the wet area on the sheet.</p> <p>On 05/02/19 at 2:29 p.m., an interview was conducted with RN # 8, the wound care nurse regarding infection control practices during wound care. RN #8 was asked what infection control procedures are implemented during wound care. RN # 8 stated, "The use of gloves, wash hands</p>	F 880			

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F 880	<p>Continued From page 189</p> <p>between tasks, keeping items in zip lock bags to secure supplies/treatments from the environment, using sanitizing wipes to clean the work surfaces, use clean barriers such as a clean towel or clean brief as a barrier to keep the bed clean." RN #8 was asked about providing a clean barrier and keeping Resident # 65's heel from touching the contaminated area on Resident # 89's bed and below his heel during the wound care, he provided. RN # 8 stated, "I should have used a clean barrier under the foot or had someone come in and help hold up his foot and the bed sheet should have been cleaned and the mattress wiped down."</p> <p>The facility's policy "Dressing Change: Non Sterile (Clean) documented, "11. Place procedure towel (wound drape) or clean towel under area for treatment."</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (administrative staff member) # 1, the interim administrator and ASM # 2, mobile administrator, ASM # 3, executive director of the assisted living facility, and ASM # 4, director of nursing were made aware of the findings.</p> <p>No further information was provided prior to exit.</p> <p>References: (1) A brain disorder that seriously affects a person's ability to carry out daily activities). This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/alzheimersdisese.html">https://www.nlm.nih.gov/medlineplus/alzheimersdisese.html</a>.</p> <p>(2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for</p>	F 880			

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F 880	<p>Continued From page 190</p> <p>short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/003213.htm">https://medlineplus.gov/ency/article/003213.htm</a>.</p> <p>(3) Low blood pressure. This information was taken from the website: <a href="https://medlineplus.gov/lowbloodpressure.html">https://medlineplus.gov/lowbloodpressure.html</a>.</p> <p>(4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm">https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm</a>.</p> <p>(5) Was specifically designed to address the problem of patient movement and its negative effect on heel offloading. Prevalon's unique dermasuede fabric interior gently grips the limb so it remains fully offloaded, even when the patient is moving. This information was obtained from the website: <a href="https://www.medline.com/product/Prevalon-Heel-Protectors-by-Sage-Products/Z05-PF26037">https://www.medline.com/product/Prevalon-Heel-Protectors-by-Sage-Products/Z05-PF26037</a>.</p> <p>(6) Honey can become contaminated with germs from plants, bees, and dust during production, collection, and processing. Fortunately, there are characteristics of honey that prevent these germs from remaining alive or reproducing. However, some bacteria that reproduce using spores, such as the type that causes botulism, can remain. This explains why botulism has been reported in infants given honey by mouth. To solve this problem, medical-grade honey (Medihoney, for example) is irradiated to inactivate the bacterial spores. Medical-grade honey is also standardized</p>	F 880			

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F 880	<p>Continued From page 191</p> <p>to have consistent germ-fighting activity. Some experts also suggest that medical-grade honey should be collected from hives that are free from germs and not treated with antibiotics, and that the nectar should be from plants that have not been treated with pesticides. This information was obtained from the website: <a href="https://medlineplus.gov/druginfo/natural/738.html">https://medlineplus.gov/druginfo/natural/738.html</a>.</p> <p>2. The facility staff failed to keep their thumbs off the food surface of dinner plates and refrain from touching resident's dinner rolls with bare hands while serving the resident's lunch.</p> <p>On 04/30/19 at 12:00 p.m., an observation was conducted in the facility's main dining room during lunch. Observation of the dining room revealed a steam table at one end of the room that contained a stack of clean dinner plates. OSM (other staff member) # 9, cook/dietary aide was observed standing behind the steam table plating food on twelve dinner plates with bare hands. Observation of OSM # 9 revealed she was preparing the steam table for the meal by bringing out the hot foods from the kitchen on a cart, placing the food containers in the steam table, opening the door to the kitchen and coming back with serving utensils, and opening packages of dinner rolls. Further observation revealed OSM # 9's hands were bare and there was no evidence of OSM # 9 using hand sanitizer or washing her hands prior to plating the resident's food. Observation of OSM # 9 revealed that when she picked up the dinner plates from the clean stack, OSM # 9's thumbs were positioned on the food surface of each plate. After placing the food on each plate, OSM # 9 reached into a bag of dinner rolls with her bare hands, removed a dinner roll</p>	F 880			



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F 880	<p>Continued From page 192</p> <p>and placed it on the plate of food for each of the twelve dinner plates served. After placing the food and dinner roll on each plate OSM # 9 then picked up the plate off the steam table and handed it the CNA (certified nursing assistant) to be taken to the residents seated in the dining room. Observation of the position of OSM # 9's hands when picking up the dinner plates revealed her thumbs positioned on the food surface of each of the twelve dinner plates.</p> <p>On 04/30/19 at 2:53 p.m., an interview was conducted with OSM # 9, cook/dietary aide. When asked to describe how staff are supposed to handle a resident's dinner plate, OSM # 9 stated, "On the outside of the plate or under the plate." OSM # 9 further stated that she was not aware of the placement of her thumbs when serving the food. When asked why it was important to keep fingers off the food surface of the plate, OSM # 9 stated, "For sanitation. Don't want to contaminate the plates." When asked about serving the resident's dinner rolls with bare hands, OSM # 9 stated, "I should have had gloves on but I was told that you can't use gloves in the dining room." When asked if there was another way she could have served the rolls, OSM # 9 stated, "I could use tongs."</p> <p>On 05/01/19 at 2:54 p.m., an interview was conducted with OSM # 7, dietary manager regarding the handling resident's dinner plates. OSM # 7 stated. "Hands and fingers should not touch the surface of the plate." When asked why they shouldn't touch the food surface of the plates, OSM # 7 stated, "To prevent contamination." When informed of the observation of OSM # 9 serving the resident's dinner rolls with bare hands, OSM # 7 stated,</p>	F 880			

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F 880	<p>Continued From page 193</p> <p>"Should not touch resident's food with bare hands. She could have used a pair of tongs."</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (administrative staff member) # 1, the interim administrator and ASM # 2, mobile administrator, ASM # 3, executive director of the assisted living facility, and ASM # 4, director of nursing were made aware of the findings.</p> <p>No further information was provided prior to exit.</p> <p>3a. The facility staff failed to follow infection control practice for the care of Resident #127's respiratory equipment, Resident #127's nasal cannula was observed directly on the floor during separate observation.</p> <p>Resident #127 was admitted to the facility on 04/04/19, with diagnoses that included but were not limited to: hypertension (1), coronary artery diseases (CAD) (2), and dementia (3).</p> <p>The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 04/15/19, coded the resident as scoring a 7 on the BIMS (brief interview for mental status) score of 0-15, 7 indicating severe cognitive impairment for daily decision-making. The resident was coded as totally dependent upon two or more staff members for all of activities of daily living. In Section O- Special treatments and programs, the resident was coded C. oxygen therapy. Section H "Bladder and Bowel" Resident # 127 was coded as "A. Indwelling catheter (including suprapubic catheter [5] and nephrostomy tube)."</p> <p>04/30/19 11:42 a.m., an observation of Resident</p>	F 880			

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F 880	<p>Continued From page 194</p> <p>#127's room revealed a nasal cannula (4) oxygen device directly on the floor uncovered.</p> <p>On 04/30/19 at 2:36 p.m. and on 05/01/19 8:11 a.m., an observation of the resident's room revealed the resident was in bed receiving oxygen by nasal cannula connected to an oxygen concentrator.</p> <p>On 05/01/19 at 9:46 a.m., an observation of Resident #127's room revealed the resident sitting on his bed finishing his breakfast. Resident 127's nasal cannula was observed resting on the floor uncovered.</p> <p>On 05/01/19 01:20 p.m., an interview was conducted with LPN #7. When asked about the process of storing respiratory equipment specifically a nasal cannula when not in use, LPN #7 stated, "It should be bagged and labeled with the resident's name, room number, the date." When asked if the nasal cannula should be on the floor uncovered, LPN #7 stated, "No." When asked why a nasal cannula should not be on the floor, LPN #7 stated, "To prevent infection to the resident."</p> <p>The physician orders dated 04/05/19 documented, "O2 (oxygen) 2 (two) liters per minute via (by) nasal cannula every shift for hypoxia."</p> <p>Review of Resident #127's electric clinical record on 05/01/19 failed to evidence a comprehensive care plan for the use of oxygen.</p> <p>The review of the facility policy titled, "Oxygen administration." Documented in part under completion of procedure, "2. When oxygen not in</p>	F 880			

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NAME OF PROVIDER OR SUPPLIER  <b>PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2125 HILLIARD ROAD</b> <b>RICHMOND, VA 23228</b>		
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F 880	<p>Continued From page 195</p> <p>use, store oxygen tubing and nasal cannula or mask in separate, labeled plastic bag."</p> <p>No further information was provided prior to exit.</p> <p>Reference:</p> <ol style="list-style-type: none"> <li>1. High blood pressure. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/highbloodpressure.html">https://www.nlm.nih.gov/medlineplus/highbloodpressure.html</a>.</li> <li>2. A common type of heart disease. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html">https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html</a></li> <li>3. A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/000739.htm">https://medlineplus.gov/ency/article/000739.htm</a>.</li> <li>4. Tubing used to deliver oxygen at levels from 1 to 6 L/min. The nasal prongs of the cannula extend approx. 1 cm into each naris and are connected to a common tube, which is then connected to the oxygen source. It is used to treat conditions in which a slightly enriched oxygen content is needed, such as emphysema. The exact percentage of oxygen delivered to the patient varies with respiratory rate and other factors. This information was obtained from the website: <a href="http://medical-dictionary.thefreedictionary.com/nasal+cannula">http://medical-dictionary.thefreedictionary.com/nasal+cannula</a>.</li> <li>5. A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder</li> </ol>	F 880			

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F 880	<p>Continued From page 196</p> <p>through a small hole in your belly. You may need a catheter because you have urinary incontinence (leakage), urinary retention (not being able to urinate), surgery that made a catheter necessary, or another health problem. This information was obtained from the website: <a href="https://medlineplus.gov/ency/patientinstructions/000145.htm">https://medlineplus.gov/ency/patientinstructions/000145.htm</a></p> <p>3b. The facility staff failed to follow infection control practice for the care of Resident's #127 indwelling urinary catheter collection bag.</p> <p>On 04/30/19 11:42 a.m., an observation of Resident #127's room revealed the resident resting in bed. Further observation revealed a urinary catheter collection bag hanging on the side of the resident's bed with the urine collection bag touching the floor. The resident's bed was observed at a low position.</p> <p>On 05/01/19 09:14 a.m., an observation of Resident #127's room revealed the resident resting in bed. Further observation revealed a urinary catheter collection bag hanging on the side of the resident's bed with the urine collection bag touching the floor.</p> <p>On 05/01/19 at 1:20 p.m., an observation of Resident #127's room was conducted with LPN #7. Observation revealed a urinary catheter collection bag hanging on the side of the resident's bed with the urine collection bag touching the floor.</p> <p>When asked if the urinary catheter bag should be touching the floor, LPN #7 stated, "No." when asked where the urinary drainage bag should be</p>	F 880			

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F 880	<p>Continued From page 197</p> <p>positioned when the resident is in bed, LPN stated, "It should be below the level of the resident but not on the floor, that is not right." LPN #7 raised Resident #127's bed to get the urinary catheter bag off the floor. When asked why the urinary catheter bag should not be on the floor, LPN #7 stated, "to prevent infection."</p> <p>Review of the facility policy titled "catheter care: Indwelling catheter" documented in part, "16. Check the tubing is not kinked, looped, clamped, or positioned above the level the bladder and off the floor. Place bag in catheter dignity bag."</p> <p>According to Lippincott Manual of Nursing Practice, Eighth Edition 2006, chapter 21, Renal and Urinary Disorders, page 757, "Maintaining a Closed Urinary Drainage System: Many UTI's (urinary tract infections) are due to extrinsically acquired organisms transmitted by cross-contamination. 2. c. Keep the drainage bag off the floor to prevent bacterial contamination".</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (Administrative Staff Member) #2, the mobile administrator, and ASM #4, the director of nursing, were made aware of the above findings.</p> <p>No further information was provided prior to exit</p> <p>4. The facility staff failed to wash or sanitize their hands after touching the food service cart, and then touched the edge of resident's plate, and the ice surface of the ice scoop while serving foods and drinks during a lunch observation in the main dining room.</p> <p>On 04/30/19 at 12:08 PM the following dining</p>	F 880			

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F 880	<p>Continued From page 198</p> <p>room observation were made in the main dining facility dining room: OSM (other staff member) #7, ancillary clerk was observed holding the ice scope with her thumb touching the serving surface of the ice scope while serving two residents seated on the far left corner of the dining room. At 12:21 p.m., OMS #7 was also observed serving 12 other residents holding the plates with her thumbs on the food surface of the plates.</p> <p>On 05/01/19 at 01:43 PM an interview was conducted with OMS #8. When asked to describe the position of the hand and finger in regards to the plate while serving the resident their foods. OSM #8 stated, "I hold the plates my thumbs on the food surface and the rest of the finger under the plate." When OSM #7 was asked to demonstrate how to hold a resident's plate, she demonstrated holding a simulated paper plate underneath the plate. When OSM #8 was asked if a server's bare thumbs should be on the top of the rim of the plate, OSM #8 stated, "Your thumbs should not be where the food is but it's hard to do otherwise to keep the plate balanced." When asked about the importance of not touching the food surface of the plate with the un-sanitized hand, OSM #8 stated, "To prevent germs from touching the foods. Maybe my hand came in contact with the cart and I did not have gloves on." When asked where the hand and fingers should be on the ice scoop when serving ice in resident's glass, OSM #8 stated, "I should hold it by the handle." When asked why is that import, OSM #8 stated, "To prevent contamination."</p> <p>On 05/01/19 2:54 p.m., an interview with OSM #7, dietary manager, regarding the handling of plates when serving resident meals. OSM #7 stated,</p>	F 880			

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F 880	<p>Continued From page 199</p> <p>"When the food leaves the kitchen, we let the aides and nursing staff handle it from there. The hand and fingers should not touch the food surface of the plate. When asked where the hand and fingers should be on the ice scoop when serving ice into resident glasses, OSM #7 stated, "I hold the ice scoop from the handle."</p> <p>On 5/1/19, the facility's policy for dining and serving meals was requested and provided. A review of the facility's policy for "Meal service" with a revision date of 02/2019, documented in part, "5. Remove plate cover. Do not touch food. Avoid touching the eating surface of plates, inside of cup/glasses, or eating surface of silverware."</p> <p>In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 655. "The nurse follows certain principles and procedures, including standard precautions, to prevent and control infection and its spread. During daily routine care, the nurse uses basic medical aseptic techniques to break the infection chain. A major component of client and worker protection is hand hygiene. Contaminated hands of health care workers are a primary source of infection transmission in health care settings."</p> <p>On 05/02/19 at approximately 3:30 p.m., ASM (Administrative Staff Member) #2, the mobile administrator, and ASM #4, the director of nursing, were made aware of the above findings.</p> <p>No further information was provided prior to exit</p> <p>5. The facility staff failed to wash or sanitize their hands after touching the food service cart, and then touched the edge of residents' plate, while</p>	F 880			



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F 880	<p>Continued From page 200</p> <p>serving food in the Arcadia dining room during a lunch dining observation.</p> <p>On 4/30/19 between 12:50 p.m. and 1:20 p.m., an observation of the Arcadia dining room was conducted.</p> <p>CNA (Certified nurse assistant) #1 and CNA #2 were observed serving resident plates with their bare hands and their thumbs on the top rims on the food contact surface of the plates as they moved the plate from the food service cart to the table and placed the plates in front of the residents. CNA #1 and CNA #2 were not observed washing or sanitizing their hands during the lunch service.</p> <p>On 5/2/19 at 1:45 p.m., an interview with CNA #3 was conducted. When CNA #3 was asked would it be a problem if the top of the rim of the plate were touched, she stated, "Contamination! We don't touch the top of the plate or touch the cup top. We hold the cup from the middle."</p> <p>A review of the facility's policy "Hand Hygiene" with effective date of 12/2009, documented in part, " ...Purpose: To decrease spread of infection ...When to wash hands or use an alcohol-based hand rub: ...After contact with inanimate objects ...in the immediate vicinity of the patient ..."</p> <p>In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 655. "The nurse follows certain principles and procedures, including standard precautions, to prevent and control infection and its spread. During daily routine care the nurse uses basic medical aseptic techniques to break the infection chain. A major component of client</p>	F 880			

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F 880	Continued From page 201 and worker protection is hand hygiene. Contaminated hands of health care workers are a primary source of infection transmission in health care settings."  On 5/2/19 at 4:02 p.m., ASM (Administrative Staff Member) #1 (Interim Administrator), ASM #2 (Mobile Administrator), ASM #4 (Director of Nursing), and ASM #3 (Education Department) were made aware of the findings.  No further information was provided by the end of the survey.	F 880			
F 917 SS=D	Resident Room Bed/Furniture/Closet CFR(s): 483.10(i)(4), 483.90(e)(2)(3)  §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv)  §483.90(e)(2) -The facility must provide each resident with-- (i) A separate bed of proper size and height for the safety and convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.  §483.90(e)(3) CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (e)(1) (i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations	F 917		5/23/19	

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F 917	<p>Continued From page 202</p> <p>(i) Are in accordance with the special needs of the residents; and</p> <p>(ii) Will not adversely affect residents' health and safety.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide functional furniture for one of 56 residents in the survey sample, Resident #58.</p> <p>Resident #58's room failed to provide a nightstand for Resident #58.</p> <p>The findings include:</p> <p>Resident #58 was admitted to the facility 11/29/18 with diagnoses that included but were not limited to: cerebral palsy [A group of disorders that affect a person's ability to move and to maintain balance and posture (1)], intellectual disability [Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness (2)] and high blood pressure.</p> <p>The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/6/19, coded the resident as having both short and long-term memory difficulties and as moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one</p>	F 917	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p style="text-align: center;">F-917</p> <p>It is the intended practice of the facility to provide functional furniture for all residents.</p> <ol style="list-style-type: none"> <li>1. Upon notification from the surveyor on May 1, 2019, resident #58 was immediately provided a night stand.</li> <li>2. Residents who reside in the facility have the potential to be affected.</li> <li>3. Staff will be re-educated on the importance of providing a homelike environment with required furnishings in residents rooms.</li> <li>4. Administrator and/or designee will randomly audit 22 resident rooms for required furnishings daily x 5 days and</li> </ol>		

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F 917	<p>Continued From page 203</p> <p>staff member for most of her activities of daily living and was coded as being dependent upon the staff for toileting and personal hygiene.</p> <p>Observation was made of Resident #58's room on 4/30/19, at approximately 11:40 a.m.; Resident #58 was in her bed, awake. Resident #58 could only answer to her name. There was no nightstand or over bed table at this time. The room appeared bare and institutionalized. There was nothing on the walls and no nightstand to put her belongings on. The other resident in the room had a nightstand and an over bed table. The closet and dresser drawers were located at the foot of the bed on the other side of the room from Resident #58.</p> <p>A second observation was made of Resident #58's room on 4/30/19 at 3:47 p.m. The resident was in the bed. There was an over bed table next to the bed but no nightstand.</p> <p>An interview was conducted with CNA (certified nursing assistant) #4 on 5/1/19 at 1:14 p.m. When asked why Resident #58 did not have a nightstand, CNA #4 stated, "I've asked for one but I will have to check on that and get back with you." When asked if Resident #58 should have a nightstand, CNA #4 stated, "Yes, Ma'am." CNA #4 showed where Resident #58's two drawers, closet space and basin with her personal belongings was located in the wall unit on the other side of the room.</p> <p>An interview was conducted with LPN (licensed practical nurse) # 4 on 5/1/19 at 1:19 p.m. When asked if every resident should have an over bed table and a night stand, LPN #4 stated, "Yes, I believe so." When asked why Resident #58 does</p>	F 917	<p>then 3 days a week x 3 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated.</p> <p>5. The facility alleged date of compliance is June 11, 2019.</p>		

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F 917	<p>Continued From page 204</p> <p>not have a night stand, LPN #4 stated, "We are working on that right now."</p> <p>An interview was conducted with administrative staff member (ASM) #2, the mobile administrator, on 5/1/19 at 1:23 p.m. When asked if every resident should have an over bed table and a night stand, ASM #2 stated, "Yes."</p> <p>The facility policy, "Respect/Dignity/Right to have Personal Property" documented in part, "Resident's possessions, regardless of their apparent value to others, must be treated with respect. Resident have the right to retain and use personal possessions to promote a homelike environment and support each resident in maintaining their independence."</p> <p>ASM #2, ASM #1, the interim administration, and ASM #3, the assisted living facility executive director, were made aware of the above concern on 5/2/19 at 10.58 a.m.</p> <p>No further information was provided prior to exit.</p> <p>(1) This information was obtained from the following website: <a href="https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html">https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html</a>.</p> <p>(2) This information was obtained from the following website: <a href="https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100">https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100</a></p>	F 917			