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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/19/2020 through 02/21/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey. The census in this 65 certified bed facility was 60 at the time of the survey. The survey sample consisted of 15 current resident reviews and 3 closed record reviews.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/19/2020 through 02/21/2020. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 65 certified bed facility was 60 at the time of the survey. The survey sample consisted of 15 current resident reviews and 3 closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or	F 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/22/2020

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inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure the right to formulate an advanced directive as evidence by the advanced directive in the resident record not completed accurately for one of 18 residents, Resident #47.

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The findings included:

For Resident #47 the facility staff failed ensure a Virginia Department of Health DDNR (durable do not resuscitate) form was complete.

Resident #47's face sheet listed diagnoses which included but not limited to acute respiratory failure, end stage renal disease, anemia, gastroesophageal reflux disease, hypothyroidism, diabetes mellitus-type 2, depression, hypertension, chronic obstructive pulmonary disease and dependence on dialysis.

Resident #47's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 01/20/2020 assigned the resident a BIMS (brief interview for mental status) score of 14 out 15 in section C, cognitive patterns.

Resident #47's clinical record was reviewed on 02/19/2020. It contained a physician's order summary for the month of February 2020 which read in part, "do not resuscitate". The clinical record also contained a Virginia Department of Health DDNR form dated 03/13/19, which read as follows:

I further certify (must check 1 or 2):
[] 1. The Patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)
[] 2. The Patient is INCAPABLE of making an informed decision about provided, withholding, or withdrawing a specific medical treatment because he/she is unable to understand the nature, extent

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or probable consequences of the proposed medical decision , or to make a rational evaluation of the risks and benefits of alternatives to that decision.
If you checked 2 above, check A, B, or C below:
[] A. While capable of making an informed decision, the Patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.
[] B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.)
[] C. The Patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf is required)

Sections I and II of the DDNR form had not been checked as directed.

The concern of the incomplete DDNR form was discussed with the administrative team (administrator, DON [director of nursing], ADON [assistant director of nursing], unit manager #1, unit manager #2 and nurse educator) during a meeting on 02/20/2020 at approximately 4:00 pm. At this time, the ADON provided the surveyor with a corrected and complete copy of the resident DDNR form.

No further information was provided prior to exit.

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F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in	F 636		

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assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, staff interview, and facility document review, the facility staff failed to comprehensively assess continence for one of 18 residents in the survey sample as evidenced by failure to assess for need of continued Foley catheter use for Resident # 8.

The findings included:

The facility staff failed to assess continence for Resident # 8.

Resident # 8 had diagnoses that included but were not limited to hypertension and cerebral

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infarction. The most recent MDS (minimum data set) assessment for Resident # 8 was a quarterly assessment with an ARD (assessment reference date) of 11/9/19. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 8's cognitive status was severely impaired.

Resident # 8 had orders that included but were not limited to, "Foley catheter 16FR (French) with 10 cc (cubic centimeter) balloon to bedside straight drainage for diagnosis hx (history) of need," which was initiated by the physician on 1/7/20.

On 2/20/20 at 9:50 am, the surveyor observed Resident # 8 lying in bed. LPN # 1 (licensed practical nurse) assisted the surveyor with observing Resident # 8's Foley catheter. The surveyor observed that Resident # 8 had a # 16 Fr Foley catheter with 10 cc balloon. The surveyor observed that the catheter tubing was secured to Resident # 8's right leg with a leg strap.

The surveyor reviewed the clinical record for Resident # 8 and did not locate any documentation that reflected that the facility staff made attempts to remove the Foley catheter from Resident # 8 to assess if Resident # 8 would have been able to void without the use of a Foley catheter.

On 2/20/20 at 3:52 pm, the surveyor made the administrator, the director of nursing, the assistant director of nursing, LPN unit manager # 1, LPN unit manager # 2, and infection preventionist aware of the findings as stated above.

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The facility policy on "Catheter: Urinary:-Justification for Use" contained documentation that included but was not limited to,
..."Policy
Patients who have urinary catheters upon admission or subsequently receive one will be assessed for removal of the catheter as soon as possible based on the following criteria:

Indwelling
" Urinary retention that cannot be treated or corrected medically or surgically, for which alternate therapy is not feasible, and which is characterized by (must have all three):
" Documented post void residual (PVR) volumes in range over 200 mls, (milliliters)
" Inability to manage the retention/incontinence with intermittent catheterization, and
" Persistent overflow incontinence, symptomatic infections, and/or renal dysfunction;
" Contamination of Stage III or IV wounds with urine which has impeded healing despite appropriate personal care for the incontinence; or
" Terminal illness or severe impairment which makes positioning or clothing changes uncomfortable, or which is associated with intractable pain.
The patient's record must include how and when the patient/resident representative was involved and informed of care and treatment including the potential use and indications for the need for a catheter, how long use is anticipated, and when and why a catheter must be removed. There must be documented evidence of a discussion."
...

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F 636	Continued From page 8 On 2/21/20 at 5:32 pm, the director of nursing informed the surveyor that Resident # 8 had orders not to remove the Foley catheter upon last admission from the hospital. The surveyor asked the director of nursing if the facility staff questioned the rationale for not removing the Foley catheter for Resident # 8. The director of nursing stated that she was unaware if any staff member questioned the rationale for not removing the Foley catheter from Resident # 8 and agreed that Resident # 8's clinical record did not contain documentation that the facility staff assessed Resident # 8 for continued need of Foley catheter. No further information regarding this issue was presented to the survey team prior to the exit conference on 2/21/20.	F 636		
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		

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and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview and facility document review, the facility staff failed to review and revise the comprehensive care plan for two of 18 residents in the survey sample, Resident # 14 and Resident # 50.

The findings included

1. The facility staff failed to review and revise the comprehensive care plan following falls for Resident # 14.

The clinical record for Resident # 14 was reviewed on 2/19/20 at 3:48 pm. Resident # 14 had diagnoses that included but were not limited to dementia and difficulty walking. The most recent MDS assessment for Resident # 14 was a quarterly assessment with an ARD (assessment reference date) of 10/21/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 14 had a BIMS (brief interview for mental status) score of 14 out of 15, which indicated that Resident # 14 was cognitively intact. Section J of the MDS assesses health conditions. In Section J1800, the facility staff documented that Resident # 14 had falls since admission or prior

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assessment.

The facility staff submitted the following facility reported incident forms to the Office of Licensure and Certification, which were reviewed during the unannounced onsite survey.

1. Facility Reported Incident for Resident # 14 dated 12/3/19 contained documentation that included but was not limited to,
..."Incident type:
Injury of unknown origin
(Handwritten note as follows) Resident was sitting up in wheelchair when this nurse and CNA (certified nursing assistant) were in room. Within 10 minutes of being in residents room, resident was noted laying over in bathroom floor with laceration noted above (L) (left) eye. Reported to (director of nursing and physician's assistant's name withheld)." ...

2. Facility Reported Incident for Resident # 14 dated 1/20/20 contained documentation that included but was not limited to,
..."Incident type:
Other
(Handwritten note as follows) Resident fell from wheelchair. Struck head on dayroom floor causing laceration (rt) (right) eyebrow and under rt eye." ...

3. Facility Reported Incident for Resident # 4 dated 2/4/20 contained documentation that included but was not limited to,
..." (Handwritten note as follows) Heard loud thud. Found Rsd (resident) in floor with small pool of blood under head. Noted lacerations x 2 to forehead." ...

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The surveyor reviewed the plan of care for Resident # 14 and did not observe that revisions had been made to the plan of care to prevent further falls from occurring following the falls that occurred on 12/3/19, 1/20/20, and 2/4/20.

The facility policy on "Falls Management" contained documentation that included but was not limited to,
..."Practice Standards
5 If a patient falls:
5.4 Update the care plan to reflect new interventions." ...

On 2/20/20 at 3:52 pm, the surveyor informed the administrator, the director of nursing, the assistant director of nursing, lpn unit manager # 1, lpn unit manager # 2, and infection preventionist that the clinical record for Resident # 14 had been reviewed and that the surveyor did not observe care plan revisions. The surveyor requested a copy of the plan of care for Resident # 14.

On 2/21/20 at 8:30 am, the facility staff provided the surveyor with a copy of the care plan for Resident # 14. The surveyor noted revisions to the plan of care that had not been on the plan of care for Resident # 14 prior to the discussion with the administrative team on 2/20/20 at 3:52 pm. The surveyor observed documentation that the revisions to Resident # 14's care plan were created on or revised on 2/20/20 and 2/21/20.

On 2/21/20 at 6:05 pm, the surveyor spoke with the director of nursing in the presence of the survey team. The director of nursing shared "Care Plan Evaluation" notes for Resident # 14 with the surveyor. The director of nursing stated

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that the facility did meet to try to put things in place for Resident # 14. The surveyor spoke with the director of nursing and informed her that the interventions that were discussed in the notes were not reflected in the plan of care for Resident # 14. The surveyor informed the director of nursing that the surveyor noted revisions to the care plan following the meeting on 2/20/20 at 3:52 pm. The director of nursing did agree that she had revised the plan of care for Resident # 14 following the meeting on 2/20/20.

No further information regarding this issue was presented to the survey team prior to the exit conference on 2/21/20.

2. For Resident #50 the facility staff failed to review and revise the care plan for ambulation.

Resident #50's diagnosis list contained diagnoses, which included, but not limited to congestive heart failure, deep venous thrombosis, rheumatoid arthritis, hypertension, edema, angina, depression, chronic kidney disease, anxiety, and depression.

Resident #50's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 01/22/2020 assigned the resident a BIMS (brief interview for mental status) score of 11 out of 15 in section C, cognitive patterns. Section G, function status, coded the resident 8 of 8 in the areas of "walks in room" and "walks in corridor". This is the equivalent of "activity did not occur, ADL (activities of daily living) activity itself did not occur".

Resident #50's comprehensive care plan was reviewed and contained a care plan for "Restorative Ambulation". This care plan showed

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a revision date of 01/13/2020 and target goal date of 04/29/2020. Interventions for this care plan included "Ambulation w/fww (front wheel walker) as tolerated, wc (wheelchair) to follow for safety".

The restorative section of the resident's clinical record contained "Restorative Nursing Record" forms for the month of December 2019, which read in part "RNA to ambulate c (with) FWW as tolerated..." This entry was marked as discontinued on 12/11/19.

Surveyor spoke with the restorative aide on 02/21/2020 at approximately 8:35 am. Surveyor asked the restorative aide if the resident was receiving restorative nursing, and the restorative aide stated that if it is not being documented, then it is not being done.

Surveyor spoke with the unit manager on 02/21/2020 at approximately 9:00 am. Unit manager stated that Resident #50 is on palliative care and is "one of our residents that doesn't get out of bed".

Surveyor spoke with the MDS coordinator on 02/21/2020 at approximately 11:50 am. MDS coordinator stated that they got their information to complete the care plan form restorative notes and documentation. Surveyor pointed out to MDS coordinator that the restorative nursing for ambulation had been discontinued in December. The MDS coordinator stated that the care plan should have been updated to reflect this.

On 02/21/2020 at approximately 12:20 pm, the MDS coordinator informed the surveyor that they were not the one who updated the care plan on 01/13/2020, and that "it was just an oversight".

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F 657	Continued From page 14 The MDS coordinator provided the surveyor with an updated copy to the resident's care plan at this time. The concern of not revising the resident's care plan was discussed with the administrative team (administrator, DON [director of nursing], ADON [assistant director of nursing], unit manager #1, unit manager #2 and nurse educator) during meeting on 02/21/2020 at approximately 6:30 pm. No further information was provided prior to exit.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review the facility staff failed to provide the necessary services to maintain good grooming and personal hygiene for 1 of 18 residents, Resident #50. The findings included: For Resident #50 the facility staff failed to ensure the resident's fingernails were trimmed and clean. Resident #50's diagnosis list contained diagnoses, which included, but not limited to congestive heart failure, deep venous thrombosis, rheumatoid arthritis, hypertension, edema, angina, depression, chronic kidney disease, anxiety, and depression.	F 677		

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Resident #50's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 01/22/2020 assigned the resident a BIMS (brief interview for mental status) score of 11 out of 15 in section C, cognitive patterns. Section G, function status, coded the resident 3/2 in the areas of personal hygiene. This is the equivalent of "extensive assistance, one person physical assist".

Resident #50's comprehensive care plan was reviewed and contained a care plan for "Resident/Patient requires assistance/is dependent for ADL (activities of daily living) care in bathing, grooming, personal hygiene..." Interventions for this care plan include "provide resident/patient with limited assist of 1 for personal hygiene (grooming)"

Surveyor observed Resident #50 on 02/19/2020 at approximately 3:00 pm. Resident's fingernails are long, ragged and have a brownish debris underneath them. Surveyor observed Resident #50 again on 02/20/2020 at approximately 11:00 am. Resident's fingernails are still long, ragged and have brownish debris underneath the nails. Surveyor again observed Resident #50 on 02/21/2020 at approximately 8:30 am. Resident continues with long, ragged fingernails containing brownish debris underneath.

On 02/21/2020 at approximately 11:40 am, surveyor asked the unit manager to observe the resident's fingernails. Unit manager stated that the resident's nails were "long and dirty" Unit manager stated that she would make sure the resident's nails were trimmed and cleaned.

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F 677	Continued From page 16 The concern of the facility staff failing to ensure the resident's nails were clean and trimmed was discussed with the administrative team (administrator, DON [director of nursing], ADON [assistant director of nursing], unit manager #1, unit manager #2 and nurse educator) during a meeting on 02/21/2020 at approximately 6:30 pm. No further information was provided prior to exit.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, clinical record review, facility record review and during the course of a complaint investigation the facility staff failed to ensure that 2 of 18 residents received treatment and care as evidenced by a failure to following physician's orders, Resident #156 and Resident #157. The finding included: 1. For Resident #156 the facility staff failed to follow physician's orders in regards to changing wound dressings. Resident 156's face sheet listed diagnoses which	F 684		

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included but not limited to perforation of intestine, severe sepsis with septic shock, colostomy status, and diarrhea.

Resident #156's admission MDS (minimum data set) with an ARD (assessment reference date) of 09/16/19 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive status.

Resident #156's comprehensive care plan contained a care plan for "Resident has actual skin beakdown. Location Wound vac to surgical abdominal wound, limited mobility, recent surgery". Interventions for this care plan included "Wound vac to abdominal surgical wound, change M/W/F and PRN (as needed).

Resident #156's clinical record was reviewed and contained a physician's order summary, which read in part "Negative Pressure Therapy to surgical site periabdominal...SET Unit to -125mmHg CONTINUOUSLY. Cleanse with wound cleanser, pat dry. Skin prep periwound. Apply transparent dressing over wound, cutting appropriate size opening for wound. Place black granufoam dressing in wound bed. Cover with occlusive dsg and secure tubing per manufacturer guide...change q (every) M-W-F & prn".

Resident 156's eTAR (electronic treatment administration record) for the month of September 2019 was reviewed and contained an entry, which read in part "Negative Pressure Therapy to surgical site periabdominal...SET Unit to -125mmHg CONTINUOUSLY. Cleanse with wound cleanser, pat dry. Skin prep periwound. Apply transparent dressing over wound, cutting

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appropriate size opening for wound. Place black granufoam dressing in wound bed. Cover with occlusive dsg and secure tubing per manufacturer guide...change q (every) M-W-F & prn". This entry was coded "NN" on 09/20/19 (Friday) and 09/25/19 (Wed). Chart code "NN" is equivalent to "No/See Nurses Notes".

Resident #156's clinical record was reviewed and contained nurse's notes, which read in part "9/20/2019 15:29 Negative Pressure Therapy To surgical site periabdominal...SET Unit to -125mmHg CONTINUOUSLY. Cleanse with wound cleanser, pat dry. Skin prep periwound. Apply transparent dressing over wound, cutting appropriate size opening for wound. Place black granufoam dressing in wound bed. Cover with occlusive dsg and secure tubing per manufacturer guide...change q (every) M-W-F & prn every day shift every Mon, Wed, Fri". This note contained no information regarding why the wound dressing was not changed.

The resident's clinical record also contained a nurse's note, which read in part "9/25/2019 12:12 Negative Pressure Therapy To surgical site periabdominal...SET Unit to -125mmHg CONTINUOUSLY. Cleanse with wound cleanser, pat dry. Skin prep periwound. Apply transparent dressing over wound, cutting appropriate size opening for wound. Place black granufoam dressing in wound bed. Cover with occlusive dsg and secure tubing per manufacturer guide...change q (every) M-W-F & prn...just changed 09/24/19 because of a lead. will change it 09/26/2019". Surveyor could not locate any information on wound vac dressing being changed on 09/24/19 or 09/26/19.

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Surveyor spoke with the DON (director of nursing) on 02/21/2020 at approximately 1:30 pm. DON stated that the wound care nurse who worked with Resident #156 was no longer employed at the facility. DON stated that they could not say why the wound dressings were not completed or documented.

The concern of not following the physician's orders was discussed with the administrative team (administrator, DON [director of nursing], ADON [assistant director of nursing], unit manager #1, unit manager #2 and nurse educator) during a meeting on 02/21/2020 at approximately 6:30 pm.

No further information provided prior to exit.

2. For Resident #157 the facility staff failed to administer the medications Ativan, Cefdinir, Cymbalta, and Neurontin per the physician's orders.

Resident #157's face sheet listed diagnoses which included but not limited to chronic obstructive pulmonary disease, myocardial infarction, congestive heart failure, presence of automatic (implantable) cardiac defibrillator, presence of cardiac pacemaker, malignant neoplasm of prostate, depression, anxiety, and pain.

Resident #157 did not have a completed MDS (minimum data set); however, the resident was alert and oriented to person, place, time and situation.

Resident #157's care plan included plans for

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"Patient has an actual infection of UTI (urinary tract infection) and is at risk for sepsis", "Resident exhibits or is at risk for alterations in comfort related to chronic pain", and "Resident is at risk for complications related to the use of psychotropic drugs. Medication: Cymbalta, Ativan...". Interventions listed for these plans included "Administer PO (by mouth) antibiotic medication(s) as ordered", "Medicate resident as ordered for pain and monitor for effectiveness...", and "Administer psychotropic medications as ordered".

Resident #157's clinical record was reviewed and contained a physician's order summary, which read in part "Ativan Tablet 0.5 mg (LORazepam) Give 1 tablet by mouth one time a day for anxiety", "Cefdinir Capsule 300 mg Give 1 capsule by mouth two times a day for UTI for 7 days", "Cymbalta Capsule Delayed Release Particles 60 mg (DULoxetine HCl) Give 1 capsule by mouth one time a day for depression", and "Neurontin Capsule 300 mg (gabapentin) Give 1 capsule by mouth before meals for Pain".

Resident #157's eMAR's (electronic medication administration record) for the month of February was reviewed and contained entries, which read in part "Ativan Tablet 0.5 mg (LORazepam) Give 1 tablet by mouth one time a day for anxiety", "Cefdinir Capsule 300 mg Give 1 capsule by mouth two times a day for UTI for 7 days", "Cymbalta Capsule Delayed Release Particles 60 mg (DULoxetine HCl) Give 1 capsule by mouth one time a day for depression", and "Neurontin Capsule 300 mg (gabapentin) Give 1 capsule by mouth before meals for Pain". The entry for the Ativan was coded "NN" on 02/08/2020-02/12/2020. Chart code "NN" is the

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equivalent of "No/See Nurses Notes".

Resident #157's nurse's notes contained notes, which read in part "2/8/2020 22:23 Ativan Tablet 0.5 mg Give 1 tablet by mouth one time a day for anxiety awaiting clarification", "2/9/2020 21:11 Ativan Tablet 0.5 MG...not available awaiting pharmacy", "2/10/2020 22:10 Ativan Tablet 0.5 MG... Awaiting upon arrival from pharmacy/script", "2/11/2020 0.5 MG Ativan Tablet 0.5 MG... medication unavailable at this time", 2/12/2020 20:52 Ativan 0.5 MG Give 1 tablet by mouth one time a day for anxiety", and "2/13/2020 07:25 Notified pharmacy for Ativan and androgel. MD notified. Change ativan 0.5mg to prn (as needed) and dc (discontinue) androgel".

Resident's eMAR entry for Cefdinir was coded "NN" on 02/08/2020 at 9 am. Resident's nurse's notes contained a note, which read in part "2/8/2020 17:49 "Cefdinir Capsule 300 MG Give 1 capsule by mouth two times a day for UTI for 7 days". There was no explanation as to why the medication was not administered.

Resident's eMAR entry for Cymbalta was coded "NN" on 02/08/2020 at 9 am. Resident's nurses notes contained a note, which read in part "2/8/2020 17:49 Cymbalta Capsule Delayed Release Particles 30 MG Give 1 capsule by mouth one time a day for Depression". There was no explanation as to why the medication was not administered.

Resident's eMAR entry for Neurontin was coded "NN" on 02/08/2020-02/10/2020 at 7:30 am. Resident's nurses notes contained notes, which read in part "2/8/2020 10:38 Neurontin Capsule

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300 MG Give 1 capsule by mouth before meals for Pain", "2/8/2020 17:52 Neurontin Capsule 300 MG Give 1 capsule by mouth before meals for Pain", 2/9/2020 10:54 Neurontin Capsule 300 MG Give 1 capsule by mouth before meals for Pain", "2/10/202010:17 Neurontin Capsule 300 MG Give 1 capsule by mouth before meals for Pain Unable to obtain from omnicell, MD aware".

Surveyor requested and was provided with a list of medications available in the facility's stat box and Omnicell. The stat box list included the medication "Cefdinir 300 mg capsule". The Omnicell list contained the medications Cefdinir 300 mg capsule, duloxetine HCl DR (Cymbalta Delayed Release) 30 mg cap, gabapentin (Neurontin) 300 mg capsule, and lorazepam (Ativan) 0.5 mg tablet.

Surveyor requested and was provided with a copy of a facility policy entitled "Automated Medication Dispensing System (AMDS) for Interim/Stat/Emergency Supply (Omnicell, Pyxis)", which read in part "Purpose: To ensure access to medically necessary medication and facilitate administration of "stat" and "first doses" by authorized Center staff. 4. Removal of Medications from the AMDS: 4.1.1 Upon receipt of a new medication order or medication needed for a PRN (as needed) order, authorized staff may obtain the first dose of medication. 4.1.2 Subsequent doses required until receipt of the medication from the pharmacy may only be obtained as each dose is needed for patient administration."

Surveyor spoke with Resident #157 on 02/21/2020 at approximately 8:20 am regarding his medications. Resident #157 stated that ---

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F 684	Continued From page 23 thought it was on the evening of --- second day in the facility (02/09/2020) before he received his medications. Surveyor spoke with unit manager on 02/21/2020 at approximately 9:20 regarding Resident 157's medications. Unit manager stated that the facility uses the Omnicell for back up pharmacy and also have a contract with a local off-site pharmacy. Unit manager could offer no explanation why the resident's medications were not obtained from the Omnicell. The concern of not administering Resident #157's medications per the physician's orders was discussed with the administrative team (administrator, DON [director of nursing], ADON [assistant director of nursing], unit manager #1, unit manager #2 and nurse educator) during a meeting on 02/21/2020 at approximately 6:30 pm. No further information provided prior to exit.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		

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indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently 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
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to assess for removal of Foley catheter and failed to have an appropriate indication for use for Foley catheter for Resident #8.

The findings included

The facility staff failed to attempt to remove the Foley catheter and failed to have an appropriate diagnosis for Foley catheter use for Resident # 8.

Resident # 8 had diagnoses that included but were not limited to hypertension and cerebral infarction. The most recent MDS (minimum data

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set) assessment for Resident # 8 was a quarterly assessment with an ARD (assessment reference date) of 11/9/19. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 8's cognitive status was severely impaired.

Resident # 8 had orders that included but were not limited to, "Foley catheter 16FR (French) with 10 cc (cubic centimeter) balloon to bedside straight drainage for diagnosis hx (history) of need," which was initiated by the physician on 1/7/20.

On 2/20/20 at 9:50 am, the surveyor observed Resident # 8 lying in bed. LPN # 1 (licensed practical nurse) assisted the surveyor with observing Resident # 8's Foley catheter. The surveyor observed that Resident # 8 had a # 16 Fr Foley catheter with 10 cc balloon. The surveyor observed that the catheter tubing was secured to Resident # 8's right leg with a leg strap.

The surveyor reviewed the clinical record for Resident # 8 and did not locate an appropriate diagnosis that would support the use of a Foley catheter for Resident # 8. The surveyor also did not locate any documentation that the facility staff made attempts to remove the Foley catheter from Resident # 8 to assess if Resident # 8 would have been able to void without the use of a Foley catheter.

On 2/20/20 at 3:52 pm, the surveyor made the administrator, the director of nursing, the assistant director of nursing, lpn unit manager # 1, lpn unit manager # 2, and infection preventionist aware of the findings as stated

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F 690	Continued From page 26 above. The facility policy on "Catheter: Urinary:-Justification for Use" contained documentation that included but was not limited to, ..."Policy Patients who have urinary catheters upon admission or subsequently receive one will be assessed for removal of the catheter as soon as possible based on the following criteria: Indwelling " Urinary retention that cannot be treated or corrected medically or surgically, for which alternate therapy is not feasible, and which is characterized by (must have all three): " Documented post void residual (PVR) volumes in range over 200 mls, (milliliters) " Inability to manage the retention/incontinence with intermittent catheterization, and " Persistent overflow incontinence, symptomatic infections, and/or renal dysfunction; " Contamination of Stage III or IV wounds with urine which has impeded healing despite appropriate personal care for the incontinence; or " Terminal illness or severe impairment which makes positioning or clothing changes uncomfortable, or which is associated with intractable pain. The patient's record must include how and when the patient/resident representative was involved and informed of care and treatment including the potential use and indications for the need for a catheter, how long use is anticipated, and when and why a catheter must be removed. There must be documented evidence of a discussion." ...	F 690		

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On 2/21/20 at 12:02 pm, the assistant director of nursing informed the surveyor that the facility staff had contacted the physician, and that the physician had given Resident # 8 a diagnosis of neurogenic bladder and referred Resident # 8 to see an urologist. The surveyor asked the assistant director of nursing if the physician had came in to assess Resident # 8 determine that Resident # 8 did in fact have neurogenic bladder. The assistant director of nursing stated that he/she would check to see if the physician saw Resident # 8 on 2/20/20.

On 2/21/20 1:10 pm, the assistant director of nursing provided the surveyor with a "Report of Consultation" form from the physician for Resident # 8. The surveyor observed that there was no documented date on the consultation form. The surveyor observed that there was an attached faxed confirmation form that listed start time as "02/21 12:48 PM."

On 2/21/20 at 5:32 pm, the director of nursing informed the surveyor that Resident # 8 had orders not to remove the Foley catheter upon last admission from the hospital. The surveyor asked the director of nursing if the facility staff questioned the rationale for not removing the Foley catheter for Resident # 8. The director of nursing stated that she was unaware if any staff member questioned the rationale for not removing the Foley catheter from Resident # 8 and agreed that Resident # 8's clinical record did not reflect an appropriate indication of use for Foley catheter nor did the clinical record have documentation of failed attempts of Foley catheter removal for Resident # 8.

No further information regarding this issue was

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F 690	Continued From page 28 presented to the survey team prior to the exit conference on 2/21/20.	F 690		
F 695 SS=D	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, resident interview, clinical record review, and facility document review, the facility staff failed to provide respiratory services for two of 18 residents in the survey sample, Resident # 8 and Resident #4. The findings included 1. The facility staff failed to administer oxygen as ordered to Resident # 8. Resident # 8 had diagnoses that included but were not limited to hypertension and cerebral infarction. The most recent MDS (minimum data set) assessment for Resident # 8 was a quarterly assessment with an ARD (assessment reference date) of 11/9/19. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 8's cognitive status was severely impaired. Section O of the MDS assesses special treatments and programs. In Section O0100, the facility staff documented	F 695		

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that Resident # 8 received oxygen therapy during the lookback period for the 11/9/19 ARD.

The plan of care for Resident # 8 was reviewed and revised on 2/20/20. The facility staff documented a focus area for Resident # 8 as "Resident exhibits or is at risk for respiratory complications related to tracheostomy and resp failure dx (diagnosis)." Interventions included but were not limited to, "O2 (oxygen) as ordered via trach mask. Monitor frequently to ensure O2 is in place and connected to concentrator."

Resident # 8 had orders that included but were not limited to, "Oxygen at 8 liters per minute via trach collar," which was initiated by the physician on 1/3/20.

On 2/20/20 at 9:32 am, the surveyor observed Resident # 8 lying in bed. The surveyor observed that the blue connector tubing was not attached to Resident # 8's trach collar and Resident # 8 was not receiving oxygen. The surveyor observed that the oxygen concentrator was set at 8 liters per min.

On 2/20/20 at 9:51 am, the surveyor and LPN # 1 (licensed practical nurse) entered Resident # 8's room. The surveyor observed LPN #1 apply gloves and reattached the blue tubing to Resident # 8's trach collar. The surveyor asked LPN # 1 if Resident # 8 orders were for continuous oxygen. LPN #1 stated, "Yes." The surveyor asked LPN #1 if he/she knew how long Resident # 8's oxygen had been disconnected. LPN #1 stated, "No, but I know they were in here doing trach care a little while ago."

The facility policy on "Oxygen: Concentrator:

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contained documentation that included but were not limited to,
..."13. Attached prescribed oxygen delivery device. Apply oxygen delivery to the resident." ...

On 2/20/20 at 3:52 pm, the administrator, the director of nursing, the assistant director of nursing, lpn unit manager # 1, lpn unit manager # 2, and infection preventionist were made aware of the findings as stated above.

No further information regarding this issue was presented to the survey team prior to the exit conference on 2/21/20.
2. For Resident #4 the facility staff failed to ensure the resident had a physician's order prior to administering oxygen.

Resident #4's diagnosis listed included diagnoses not limited to convulsions, pneumonia, morbid obesity, peripheral vascular disease, diabetes mellitus-type 2, chronic obstructive pulmonary disease, congestive heart failure, dyspnea, and dependence on supplemental oxygen.

Resident #4's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/08/19 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns.

Resident #4's comprehensive care plan was reviewed and contained a care plan for "Congestive Heart Failure-Clinical Management". Interventions for this care plan include "Administer oxygen as ordered/indicated".

Surveyor observed the resident on 02/20/2020 at approximately 1:30 pm. Resident was resting in

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bed, with 02 tubing lying on the bed. Surveyor observed an oxygen concentrator in the floor beside the resident's bed. Surveyor spoke with the resident and asked the resident if they used 02 all the time, and the resident stated, "Only when I need it".

Resident #4's clinical record was reviewed on 02/20/2020. The surveyor could not locate a physician's order for the resident to receive oxygen.

Surveyor spoke with the unit manager on 02/21/2020 at approximately 8:30 am regarding Resident #4's oxygen. Unit manager stated that resident should have a physician's order for oxygen administration.

On 02/21/20 at approximately 09:30 AM, the unit manager informed the surveyor that Resident #4 was started on 02 in the ER on 11/19. Unit manager provided the surveyor with a copy of the admission summary from resident's readmission on 11/01/19, which read in part "Respiratory system reviewed 6. respiratory care needs f. 02 at 2 L/min (liters per minute) by nasal canula (sic)/mask (new)". The unit manager stated that there was no other order other than what stated on the admission summary.

The concern of administering oxygen to the resident without a physician's order was discussed with the administrative team (administrator, DON [director of nursing], ADON [assistant director of nursing], unit manager #1, unit manager #2 and nurse educator) during a meeting on 02/21/2020 at approximately 6:30 pm.

No further information provided prior to exit.

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F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, and clinical record review, the facility staff failed to provide routine and emergency drugs and biologicals for one of 18 residents, Resident	F 755		

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#157.

The findings included:

For Resident #157 the facility staff failed to ensure the medications AndroGel, Atrovent, and Ventolin were available for administration.

According to the Physician's Desk Reference, AndroGel is a hormonal agent used for hormone replacement in males to treat hypogonadism due to medical conditions.

According to the Physician's Desk Reference, Atrovent is an inhaled medication used to treat COPD in adults.

According to the Physician's Desk Reference, Ventolin is an inhaled medication used to treat COPD in adults.

Resident #157's face sheet listed diagnoses which included but not limited to chronic obstructive pulmonary disease, myocardial infarction, congestive heart failure, presence of automatic (implantable) cardiac defibrillator, presence of cardiac pacemaker, malignant neoplasm of prostate, depression, anxiety, and pain.

Resident #157 did not have a completed MDS (minimum data set); however, the resident was alert and oriented to person, place, time and situation.

Resident #157's clinical record was reviewed and contained a physician's order summary, which read in part "AndroGel 20.25.MG/1.25 GM (1.62%) (Testosterone) Apply 1 pump

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transdermally one time a day for Hormone replacement related to MALIGNANT NEOPLASM OF PROSTATE (C61) Put on --- thigh", "Atrovent HFA Aerosol Solution 17 MCG/ACT (Ipratropium Bromide HFA) 2 puff Inhale orally four times a day for COPD (chronic obstructive pulmonary disease)" and "Ventolin HFA Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate HFA) 2 puff inhale orally four times a day for COPD".

Resident #157's eMAR (electronic medication administration record) for the month of February 2020 was revived and contained entries, which read in part "AndroGel 20.25.MG/1.25 GM (1.62%) (Testosterone) Apply 1 pump transdermally one time a day for Hormone replacement related to MALIGNANT NEOPLASM OF PROSTATE (C61) Put on --- thigh", "Atrovent HFA Aerosol Solution 17 MCG/ACT (Ipratropium Bromide HFA) 2 puff Inhale orally four times a day for COPD (chronic obstructive pulmonary disease)" and "Ventolin HFA Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate HFA) 2 puff inhale orally four times a day for COPD". The entry for the AndroGel was coded "NN" on 02/08/2020-02/12/2020. Chart code "NN" is equivalent to "No/See Nurse Notes". Surveyor reviewed the nurse's notes in the notes section of the resident's clinical record, and located notes related to the AndroGel, which read in part "2/8/2020 22:23 AndroGel gel 20.25 MG/1.25 GM (1.62%) Apply one pump transdermally one time a day for Hormone replacement Put on --- thigh waiting clarification", "2/9/2020 21:10 AndroGel Gel 20.25.MG/1.25 GM (1.62%) Apply 2 pump transdermally one time a day for Hormone replacement Put on --- thigh awaiting delivery from pharmacy", "2/10/2020 22:23 AndroGel Gel 20.25.MG/1.25 GM....awaiting arrival to the

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facility/script", "2/11/2020 21:20 AndroGel Gel 20.25/1.25 MG....medication not available awaiting on arrival from pharmacy", "02/12/2020 20:51 AndroGel Gel 20.25 MG/1.25 GM...not available" and "2/13/2020 7:25 Notified pharmacy for Ativan and androgel. MD notified. Change ativan 0.5mg to prn (as needed) and dc (discontinue) androgel"

The entry on the resident's eMAR for Atrovent was coded "NN" on 02/08/2020 at 9am, 1pm, 5pm and 02/09/2020 at 5pm. Nurse's notes for these dates were reviewed and read in part, "2/8/2020 17:48 Atrovent HFA Aerosol Solution 17 MCG/ACT 2 puff inhale orally four times a day for COPD", and "2/9/2020 21:11 Atrovent HFA Aerosol Solution 17 MCG/ACT 2 puff inhale orally four times a day for COPD awaiting delivery from pharmacy".

The entry on the resident's eMAR for Ventolin was coded "NN" on 02/08/2020 at 9a, 1p, 5p and 02/10/2020 at 1p. Nurse's notes for the dates were reviewed and read in part "2/8/2020 17:53 Ventolin HFA Aerosol Solution 108 (90 Base) MCG/ACT 2 puff inhale orally four times a day for COPD" and "2/10/2020 12:40 Ventolin HFA Aerosol Solution 108 (90 Base) MCG/ACT....on order".

Surveyor spoke with Resident #157 on 02/21/2020 at approximately 8:20 am regarding his medications. Resident #157 stated that --- thought is was on the evening of --- second day in the facility (02/09/2020) before he received his medications.

Surveyor spoke with the unit manager on 02/21/2020 at approximately 9:20 am regarding

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F 755	Continued From page 36 Resident #157's medications. Unit manager stated that each resident has a physician's order to start meds when they arrive from pharmacy. The concern of the facility not ensuring the resident's medications were available for administration was discussed with the administrative team (administrator, DON [director of nursing], ADON [assistant director of nursing], unit manager #1, unit manager #2 and nurse educator) during a meeting on 02/21/2020 at approximately 6:30 pm. No further information was provided prior to exit.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and during the course of medication pass and pour observation facility failed to ensure a medication rate less than 5% as evidenced by observation of three medication errors in 35 opportunities. The medication error rate was 8.57 percent. The findings included: On 2/20/20 at 8:01 am, the surveyor conducted a medication pass and pour observation with LPN # 1 (licensed practical nurse). During the medication pass and pour observation, the	F 759		

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surveyor observed LPN # 1 administer enteric coated aspirin 81 mg to Resident # 1, Resident #7 , and Resident # 21. Upon completion of the medication pass and pour observation, the surveyor verified the physician's orders and noted that Resident # 1 had orders that included but were not limited to "Aspirin 81 mg give 1 tablet by mouth one time a day related to unspecified atrial fibrillation," which was initiated by the physician on 12/15/19. The surveyor observed that Resident # 1's aspirin order did not state to administer enteric coated. Resident # 7 had orders that included but were not limited to "Aspirin 81 mg give 1 tablet by mouth one time a day for supplement related to thrombocytopenia," which was initiated by the physician on 8/9/18. The surveyor observed that Resident # 7's aspirin order did not state to administer enteric coated. Resident # 21 had orders that included but were not limited to, "Aspirin 81 mg give 1 tablet by mouth one time a day related to acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity," which was initiated by the physician on 12/19/19. The surveyor observed that Resident # 21's aspirin order did not state to administer enteric coated.

On 2/20/20 at 10:42 am, the surveyor interviewed LPN # 1. The surveyor asked LPN # 1 how he/she would know when to administer chewable aspirin versus enteric-coated aspirin. LPN # 1 stated, "I guess we would have to get it clarified which one to give."

On 2/20/20 at 3:52 pm, the administrator, the director of nursing, the assistant director of nursing, LPN unit manager # 1, LPN unit manager # 2, and infection preventionist were made aware of the findings as stated above.

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F 759	Continued From page 38 No further information regarding this issue was presented to the survey team prior to the exit conference on 2/21/20.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review the facility staff failed to ensure that one of 18 residents were free of significant medication errors, Resident #157. The findings included: For Resident #157 the facility staff failed to ensure the medication ticagrelor was available for administration. According to Drugs.com, ticagrelor (generic name for Brilinta) is used to prevent platelets in the blood from sticking together to form an unwanted blood clot. Resident #157's face sheet listed diagnoses which included but not limited to chronic obstructive pulmonary disease, myocardial infarction, congestive heart failure, presence of automatic (implantable) cardiac defibrillator, presence of cardiac pacemaker, malignant neoplasm of prostate, depression, anxiety, and pain. Resident #157 did not have a completed MDS	F 760		

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(minimum data set); however, the resident was alert and oriented to person, place, time and situation.

Resident #157's care plan contained a plan for "Resident is at risk for injury or complications related to the use of anticoagulation therapy medication: Apixaban and Brilinta". Interventions for this care plan included "Anticoagulant to be given as ordered".

Resident #157's clinical record was reviewed and contained a physician's order summary, which read in part "Ticagrelor Tablet 90 MG Give 1 tablet by mouth two times a day for MI (myocardial infarction) related to NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION".

Resident 157's eMAR (electronic medication administration record) was reviewed and contained as entry, which read in part "Ticagrelor Tablet 90 MG Give 1 tablet by mouth two times a day for MI (myocardial infarction) related to NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION". This entry was coded "NN" on 02/08/2020 at 9a and 9p. Chart code "NN" is the equivalent to "No/See Nurses Notes".

Resident #157's nurse's notes were reviewed and contained notes, which read in part "2/8/2020 17:51 Ticagrelor Tablet 90 MG Give 1 tablet by mouth two time a day for MI", and "2/8/2020 22:25 Ticagrelor Tablet 90 MG Give 1 tablet by mouth two time a day for MI awaiting clarification".

According to the "Physician's Desk Reference", patients should "avoid interruption or abrupt

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F 760	Continued From page 40 discontinuation of ticagrelor treatment...Discontinuation of ticagrelor increases the risk of myocardial infarction, stent thrombosis, and death." Surveyor spoke with the unit manager on 02/21/2020 at approximately 9:20 am regarding Resident #157's medications. Unit manager stated that each resident has a physician's order to start meds when they arrive from pharmacy. The concern of the facility not ensuring the resident was free of a significant medication error was discussed with the administrative team (administrator, DON [director of nursing], ADON [assistant director of nursing], unit manager #1, unit manager #2 and nurse educator) during a meeting on 02/21/2020 at approximately 6:30 pm. No further information was provided prior to exit.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		

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§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, and during the course of a medication pass and pour observation, the facility failed to ensure that medications were labeled and stored properly in two of 3 medication carts and one of 2 medication storage rooms.

The findings included:

The facility staff failed to ensure that medication was properly labeled on an insulin package for Resident # 21.

On 2/20/20 at 8:01 am, the surveyor conducted a medication pass and pour observation with LPN # 1 (licensed practical nurse). During the medication pass and pour observation, the surveyor observed LPN # 1 pull medication for Resident # 21. The package was labeled as "Inject 10 units subcutaneously every morning and inject 50 unit subcutaneously at bedtime." LPN # 1 turned the dial on the insulin pen to deliver 20 units and showed it to the surveyor. The surveyor observed LPN # 1 administer 20 units of insulin to Resident # 21.

The surveyor reviewed the physician's orders for

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Resident # 21. The surveyor observed that Resident # 21 had orders that included but was not limited to, "Insulin Detemir Solution 100 unit/ml (milliliter) Inject 20 unit subcutaneously in the morning for diabetes," which was initiated by the physician on 2/3/20.

On 2/20/20 at 10:42 am, the surveyor and LPN # 1 observed the insulin packaging for Resident # 21. LPN # 1 agreed that the insulin packaging was not labeled to reflect the appropriate dosage as ordered by the physician.

On 2/20/20 at 3:52 pm, the administrator, the director of nursing, the assistant director of nursing, lpn unit manager # 1, lpn unit manager # 2, and infection preventionist were made aware of the findings as stated above. The surveyor requested a copy of the facility policy and standard of practice for medication storage and labeling.

On 2/21/20 at 1:38pm, Lpn unit manager # 1 informed the surveyor that the facility did not have a policy or standard of practice on medication storage and labeling.

No further information regarding this issue was presented to the survey team prior to the exit conference on 2/2/20.

2. For the medication room on South unit and the medication cart on North unit, the facility staff failed to discard expired medications.

On 02/20/2020 at approximately 10:50 am, the surveyor observed the medication storage room on the South unit of the facility. Surveyor observed a bottle of aspirin 325 mg tablets with an expiration date of 11/19. Surveyor spoke with

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F 761	Continued From page 43 unit manager regarding the bottle of aspirin. Unit manager stated that the facility does not use 325 mg aspirin, or any of the medications located in the cabinet with the aspirin. Unit manager removed the expired bottle and discarded it at this time. On 02/20/2020 at approximately 11:10 am, the surveyor observed the medication cart located on the south unit of the facility. Surveyor observed a box contained injectable epinephrine 0.3 mg (Epi-Pen) with an expiration date of 09/19. Surveyor asked LPN #1 (licensed practical nurse) to confirm the expiration date on the box, and LPN #1 confirmed that the medication was expired and removed it from the medication cart. The concern of the facility not disposing of expired medications was discussed with the administrative team (administrator, DON [director of nursing], ADON [assistant director of nursing], unit manager #1, unit manager #2 and nurse educator) during a meeting on 02/20/2020 at approximately 4:00 pm. No further information was provided prior to exit.	F 761		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the	F 849		

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resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.

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(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice

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administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

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

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F 849	Continued From page 47 (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review, the facility staff failed to provide hospice services for one of 18 residents in the survey sample as evidenced by failure to ensure that the clinical record had an updated hospice plan of care in the clinical record and failed to ensure that hospice notes were in the clinical record for Resident # 14.	F 849		

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The findings included

The clinical record for Resident # 14 was reviewed on 2/19/20 at 3:48 pm. Resident # 14 had diagnoses that included but were not limited to dementia and difficulty walking. The most recent MDS assessment for Resident # 14 was a quarterly assessment with an ARD (assessment reference date) of 10/21/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 14 had a BIMS (brief interview for mental status) score of 14 out of 15, which indicated that Resident # 14 was cognitively intact.

The plan of care for Resident # 14 was reviewed and revised on 2/20/20. The facility staff documented a focus area for Resident # 14 as, "Hospice start date 7/18/19 Hospice care due to end stage diagnosis of ALS (Lou Gehrig's disease)." Interventions included but were not limited to, "Hospice nursing 2-3 x/week & PRN (as needed) to assess and manage symptoms, comfort/pain," and "Hospice nursing assistant 2-3 x/week to compliment ADL (activities of daily living) care, provide comfort and hygiene." Resident # 14 had orders that included but was not limited to "Hospice care and treat," which was initiated by the physician on 7/18/19.

The surveyor reviewed the clinical record for Resident # 14 and did not observe any hospice notes or a current hospice plan of care in the clinical record for Resident # 14.

On 2/20/20 at 3:52 pm, during the end of day meeting, the surveyor made the administrator, the director of nursing, the assistant director of nursing, LPN (licensed practical nurse) unit

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manager # 1, LPN unit manager # 2, and infection preventionist aware that the hospice notes and hospice plan of care could not be located in Resident # 14's clinical record. The assistant director of nursing informed the surveyor that the hospice notes and plan of care were kept in a separate binder at the nurse's station.

On 2/21/20 at 1:00 pm, LPN unit manager # 1 provided the surveyor with a stack of papers contained 185 pages that had been faxed from the hospice company. LPN unit manager # 1 informed the surveyor that the hospice company would be faxing over an additional stack of pages, and that the hospice provider had not been ensuring that the hospice notes and plan of care were in the clinical record for Resident # 14.

The "Hospice Facility and Services Agreement" contained documentation that included but was not limited to,
..."2. Duties and Obligations of Hospice
2.7 Coordination of Services Hospice shall ensure the continuity of care for hospice patients and their families in all care settings. Hospice will be responsible for coordinating patient care conferences, periodic patient and family assessments and evaluations, discharge planning and bereavement follow-up for all hospice patients and their families. Hospice will also be responsible for the interdisciplinary team care conferences to the extent they involve patients currently receiving care at facility. Hospice shall designate a member of each interdisciplinary group who is responsible for (i) providing overall coordination of the hospice care for the hospice patient at the facility with facility representatives; and (ii) communicating with the facility

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F 849	Continued From page 50 representatives and other health care providers participating in the care of the hospice patient's terminal illness and related conditions and such other conditions to ensure the quality of care for the hospice patient and the family. Hospice shall provide facility with the following information specific to each hospice patient residing at the facility: (i) The most recent hospice plan of care." ... On 2/21/20 at 6:42 pm, the administrator, the director of nursing, the assistant director of nursing, LPN unit manager # 1, LPN unit manager # 2, and infection preventionist were made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 2/21/20.	F 849		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		

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F 883	Continued From page 51 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 883		

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Based on clinical record review, staff interview, clinical record review and facility document review, the facility staff failed to ensure that pneumococcal immunization was administered to one of 18 residents in the survey sample as evidenced by failure to administer follow up immunization dose for Resident # 17.

The findings included

The surveyor reviewed the clinical record for Resident # 17 on 2/21/20 at 9:02 am. The surveyor observed documentation in the clinical record that reflected that Resident # 17 had received PCV (Prevnar) 13 on 10/13/18. The surveyor did not observe documentation of a follow up vaccination to the Prevnar 13 in the clinical record for Resident # 17.

On 2/21/20 at 10:14 am, the surveyor observed a "Pneumococcal Vaccine Informed Consent" form that had been signed by Resident # 17 on 10/12/18 giving the facility permission to administer the pneumococcal vaccination. The surveyor also noted documentation on the pneumococcal vaccine informed consent form that included but was not limited to,

..."For persons 64 and younger with high risk conditions, the pneumococcal vaccination series will be administered based on the CDC guidelines as determined by the physician." ...

On 2/21/20 at 2:28 pm, the surveyor interviewed the facility infection preventionist. The surveyor asked for documentation of a follow up vaccination to Prevnar 13 for Resident # 17. The facility infection preventionist informed the surveyor that he/she would review Resident #

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 02/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(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 883	Continued From page 53 17's clinical record and follow up with the surveyor. On 2/21/20 at 3:05 pm, the facility infection preventionist informed the surveyor that Resident # 17 did not receive a follow up vaccination to the Prevnar 13 dose that had been administered on 10/13/18. The infection preventionist acknowledged that Resident # 17 should have received a follow up PPSV 23 eight weeks after the Prevnar 13 was administered. On 2/21/20 at 6:42 pm, the administrator, the director of nursing, the assistant director of nursing, lpn unit manager # 1, lpn unit manager # 2, and infection preventionist were made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 2/21/20.	F 883		