STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakhurst Health & Rehabilitation	4238 James Madson Highway Fork Union, VA 23055

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40027 Based on observation, staff interview, clinical record review, the facility staff failed to ensure a dignified dining experience during lunch observation for one of 19 residents in the survey, Resident #40. Resident #40, was identified as needing to be fed, was fed by a staff member who stood over the resident while feeding her. Findings include: Resident #40, was admitted to the facility on [DATE]. Diagnoses included malnutrition, Vitamin D Deficiency, falls, dehydration, acute kidney failure, hypernatremia, Alzheimer's Dementia, osteoporosis, septic shock, encephalopathy, and hospice services. The most recent minimum data set (MDS) dated [DATE], was a quarterly assessment and assessed Resident #40 as being severely cognitively impaired with a score of 1 out of 15. The MDS dated [DATE], under Section G (Functional Status), at item G0110 (H), Eating assessed Resident #40 as requiring extensive assistance with one-person physical assistance for eating. A dining observation was conducted in the main dining room during lunch on 03/19/19 at approximately 12:05 p.m. During the meal observation, Resident #40 was observed sitting in a geri-chair seated at a table in the main dining room. The resident's dining tray was brought to her by certified nursing assistant (CNA #1). CNA #1 was observed feeding Resident #40 and remained standing while she fed her the entire meal observation which was approximately 25 minutes. On 3/19/19 at approximately 12:45 p.m., CNA #1 was interviewed regarding Resident #40's need for assistance at meals. CNA #1 stated the resident required feeding assistance at all meals. On 3/19/19, Resident #40's clinical record was reviewed. Resident #40's care plan documented the following: Focus area: [Resident #40], requires extensive to total assistance with ADLs (activities of daily living) at this time due to impaired cognitive status, impaired mobility, impaired range of motion, non-ambulatory .is receiving hospice services. Created on 11/26/2018. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2019
NAME OF PROVIDER OR SUPPLIER: Oakhurst Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 4238 James Madson Highway, Fork Union, VA 23055	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goal: [Resident #40], needs will be met daily through next review. Created on 11/26/18. Target Dated 05/19/19. Interventions: assist with eating at meal time. Created on 11/26/18. These findings were discussed during a meeting on 03/19/19 at 4:30 p.m. with the Administrator, Director of Nursing and Nurse Consultant.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27353 Resident #8 was admitted to the facility on [DATE]. Diagnoses for this resident included, but were not limited to: MS (multiple sclerosis), depression, anxiety, seizure disorder, bipolar disorder, neurogenic bladder, hypothyroidism, and hemiplegia. The most recent MDS (minimum data set) was an annual assessment dated [DATE]. This MDS documented the resident with a cognitive score of 13, indicating the resident was cognitively intact for daily decision making skills. This resident was assessed as requiring extensive assistance for most all ADLs (activities of daily living) with assistance of one staff and required total assistance for transfers and bathing with assistance of two staff. On 03/19/19 at 10:50 AM, Resident #8 was interviewed and stated that she had a complaint. The resident stated that an aide had stated to her hat she was going to punch the resident in the face. The resident stated that she didn't know why the aide said that to her, but stated that maybe it was dominance and stated that the aide has continued working and providing care for her. The resident stated that she doesn't like to have this aide care for her due to what has happened. The resident described the CNA's age, gender and race. The resident stated that she did not know how long the CNA had been at the facility, but stated .probably longer than me. The resident stated that the CNA works with her often. The resident stated that this incident happened about a month ago. The resident stated that this was reported to the administrator and SW (social worker). The resident was asked what the administrator said to her when this was reported. The resident stated that the administrator stated, we can't have that and that was about it. The resident was asked if the administrator asked for specific details. The resident stated that both did talk to her and ask questions, but she didn't know if anything was written down. The resident stated that she could not remember what the SW had said to her about the incidences. The resident again stated that the CNA had been working with her since it was reported. The resident provided a name of the CNA, but stated that she was not exactly sure if that was her name, but stated, It was something like that. On 03/19/19 at 11:00 AM, the administrator was asked for any information regarding any allegations of abuse, complaints and/or concerns regarding this resident. The administrator stated that he was aware of one incident and would present that information. The administrator was asked to check if there were any reports to the SW for any type of abuse or mistreatment for this resident. On 03/19/19 at 12:33 PM, the administrator presented the information (unrelated incident) and stated that he had another documented concern for this resident that was during the fall of 2018. The administrator was asked for that information, in addition to any other allegations, concerns or incidents regarding this resident. On 03/20/19 at 8:45 AM, the administrator presented the concern from the fall 2018. The complaint/grievance report was reviewed and documented this event occurred on 09/17/18. The administrator stated that this was the only other thing the facility had on this resident. The administrator stated that he did not know of or have any information and/or reports from the resident or anyone else that the resident alleged that a CNA had told the resident she was going to punch her in the face. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The complaint/grievance documented, .[name of Resident #8] SW (social worker) .verbal .other .reported that she noticed CNA [certified nursing assistant] #2 with her boyfriend and other CNAs in resident room on Saturday 09/08 or Sunday 09/09, reported that she did not remember the day .CNA #3 CNA #2 [documented this statement] .[name of resident] light was on I went to answer her light she asked if I was her CNA I told her no her respond [sic] was then what are you doing here please get my aid [sic] and get out I told her she her she's [illegible word] and walk [sic] out about an hour after I herd [sic] her making a complain [sic] to my mom saying that I took her tray before she start [sic] eating I went in there and I ask her if I took her tray she said yes at lunch time I told her is [sic] supper time now she turn to me and said anyways leave bitch as I was walking out I turn back and ask what she said she said you herd [sic] me bitch leave your a bitch I turn to her and said yes I am and went to [name of nurse] and tod [sic] what happened [signature of CNA #2] On 03/20/19 at 4:44 PM, after review of the above, the administrator and DON were made aware of concerns regarding this incident in a meeting with the survey team. The administrator was asked if he or the DON had read the statement by CNA #2. The administrator and DON stated, No. The statement was read aloud and given to each to read. The administrator was asked who is supposed to look at these to ensure that they are being done correctly, to ensure that the grievance/complaint is accurate and complete. The administrator stated, You can look at me, I'm suppose to read those. The administrator stated that he did not know that was in there or didn't recall reading that initially in September. The administrator was asked what he thought about it. The administrator stated, It isn't good. The administrator was asked, what was the expectation on how staff are to respond to residents who may be upset or having behavior issues. The administrator stated, Not like that, that's unacceptable. The administrator stated that staff are trained on how to respond and interact with residents in different types of situations, but stated that regarding this incident it was not caught in September and there was no education provided for this staff regarding this, primarily because this was not found at the time. On 03/21/19 at 9:45 AM, the SW was interviewed regarding the complaint/grievance process. The SW presented a clinical guideline for complaint/grievance that documented, .The grievance officer/designee shall act on the grievance and begin follow up of the concern or submit it to the appropriate department director for follow up .should be completed within 14 days once the follow up is complete, the results should be forwarded to the executive director for review and filing . The SW stated that he is the one who completed the form and once it is completed it goes to the administrator for review. No further information and/or documentation was presented prior to the exit conference on 03/21/19 to evidence that Resident #8 was treated with dignity regarding the above.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27353 Based on resident interview, staff interview, clinical record review and facility document review, the facility staff failed to implement written policies and procedures for the prevention of abuse and investigation of abuse allegations, for one of 19 residents in the survey sample, Resident #8. Findings include: Resident #8 was admitted to the faintly on 05/30/17. Diagnoses for this resident included, but were not limited to: MS (multiple sclerosis), depression, anxiety, seizure disorder, bipolar disorder, neurogenic bladder, hypothyroidism, and hemiplegia. The most recent MDS (minimum data set) was an annual assessment dated [DATE]. This MDS documented the resident with a cognitive score of 13, indicating the resident was cognitively intact for daily decision making skills. This resident was assessed as requiring extensive assistance for most all ADLs (activities of daily living) with assistance of one staff and required total assistance for transfers and bathing with assistance of two staff. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/19 at 10:50 AM, Resident #8 was interviewed and stated that she had two complaints. The resident stated first, that an aide had stated to her that she was going to punch the resident in the face. The resident stated that she didn't know why the aide said that to her, but stated that maybe it was dominance and stated that the aide has continued working and providing care for her. The resident stated that she doesn't like to have this aide care for her due to what has happened in the past. The resident then stated that she was also sexually assaulted by those girls in the shower room, by 5 or 6 girls, including the girl that stated that she was going to punch her in the face. The resident stated that she had reported it to the administrator the following day and the incident happened on the 3-11 shift. The resident could not remember the date, but did state that it was about a month ago. The resident also stated that she also reported it to the SW (social worker). The resident called the administrator and SW by name, but stated that she did not remember the CNA's name (s) that assaulted her, but stated what she thought the name was. The resident again repeated that it was on the 3-11 shift and that she really didn't want to take a shower that day, but ended up going and that is what happened. The resident gave the name again for the CNA that she alleged was going to punch her in the face, which was also was one who was involved in the sexual assault (per the resident). The resident stated that she was not absolutely sure if that was her name, but it was something like that. The resident was asked if she went to the hospital after reporting that she was sexually assaulted, the resident stated, No. The resident was asked if anyone assessed or examined her after this was reported, the resident stated, No. The resident described the CNA by age, gender and race. The resident stated that she did not know how long the CNA has been at the facility, but stated .probably longer than me. The resident stated that the CNA works with her often. The resident stated that this incident happened about a month ago. The resident was asked what the administrator said to her when this was reported. The resident stated that when she reported that the CNA voiced punching her in the face, the administrator stated, we can't have that and that was about it. The resident stated that both incidences happened about a month ago and both were reported to the administrator and the SW. The resident was asked if the administrator asked for specific details. The resident stated that both the administrator and SW did talk to her and ask questions, but she didn't know if anything was written down. The resident stated that she could not remember what the SW had said to her about the incidences. The resident again stated that the CNA had been working her since it was reported. On 03/19/19 at 11:00 AM, the administrator was asked for any information regarding any allegations of abuse, complaints and/or concerns regarding this resident. The administrator was asked to check with the SW for any type of documentation or information regarding abuse or mistreatment for this resident. On 03/19/19 at 12:33 PM, the administrator presented a folder with a typed document from the DON (director of nursing). The administrator stated that he was aware of the alleged sexual assault and that this was the investigation. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation was reviewed. The investigation folder contained one typed document by the DON. The information documented, 03/06/19 Insurance representative along with ED [executive director] came to my office r/t [related to] conversation she [sic] had with [name of resident] .reported to her [sic] that she was taken to the shower the prior evening and raped by 5 women .I was here on 03/05/19, at appox 2 PM . resident was sitting at the nurse's station after returning from an appointment .eczema looked considerably worse .asked the assigned CNA to shower her .[name of resident] did not want to take shower .but did agree .[name of CNA #1] with assistance of [name of CNA #2] completed .shower .put to bed .diagnoses of bipolar and anxiety .over the past months has become more confused .[name of resident] was drowsy, but able to put words together that made sensible sentences .asked .anything strange happened in the last couple of days .you heard about my shower .specifically what happened .a lot of women raped me .strange women . explained I needed more details .was not able to provide any .explained that CNA #1 gave her shower with assist of CNA #2 .explained that what she is reporting is just not possible .you know me I probably dreamed it .starting to slur her words a little and was having hard time keeping her eyes open. I told her I'd let her rest, to let staff know if she wanted to talk more later and I would come back at that time the conversation ended . No other information was provided regarding this incident. The resident's CCP (comprehensive care plan) was reviewed and documented, .requires mechanical lift with 2 staff .totally dependent on staff for catheter/incontinence care .if exhibits behaviors (hypersexual conversation, request to speak to male staff members, suspicions of others, resistive to care, ask staff for money, paranoia, mood swings, states staff is outside of her room talking about her) make sure she is safe and re-approach later . On 03/20/19 at 4:44 PM, the administrator and DON were made aware of concerns regarding this incident in a meeting with the survey team. The administrator stated that he knows his residents pretty well and felt like if he thought something like that had actually occurred he would have reported it. The administrator was made aware that this was an allegation of abuse and that abuse allegations are not only investigated or reported if the allegation actually happened. The administrator was made aware that this was an allegation of abuse made a resident of this facility. The DON and administrator both stated that this resident has been known to say things that weren't true. The administrator and DON were made aware that this was an allegation of abuse and should have been reported. The administrator stated, It was not a reported FRI [facility reported incident], but stated that he has since been educated. A policy on abuse was requested at this time. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy Policies and Procedures Subject: Resident Abuse was presented and reviewed and documented the following: .policies and procedures to protect these rights to establish a disciplinary policy, which results in fair and timely treatment of occurrences of resident abuse .No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment .against any resident .abuse .physical abuse .verbal abuse .sexual abuse .neglect .questions may arise as to what actions constitute abuse of a resident. Any action that may cause actual physical, psychological or emotional harm .non-action, which results in emotional, psychological .all employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights .Any employee, who witnesses or has knowledge of an act of abuse or an allegation of abuse .is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator and to other officials in accordance with State law .An employee shall be deemed to have violated his obligations .if he does any of the following: fails to report an incident of abuse witnessed by or known .incomplete report of abuse .monitor residents at risk . all reported events .will be investigated .once an allegation of abuse is reported, the executive director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations .recognizes that preliminary reports of abuse can sometimes be clouded by biases and other factors that are relevant and need to be explored during a full investigation in order to obtain a clear picture of what actually happened .immediately upon an allegation of abuse or neglect, the suspect(s) shall be segregated from residents pending the investigation of the allegation .the clinical nurse in charge of director of clinical services shall perform and document a thorough nursing assessment and notify the attending physician .and incident report shall be filed .report the results .to the executive director .including to the State Survey Agency, within 5 working days . The resident's clinical record did not reveal any additional information or documentation regarding this incident. No evidence of any type of mental and/or physical assessment had been completed for this resident, as a result of the alleged sexual assault allegation. The administrator and DON stated that they were unaware of an allegation by Resident #8 of a CNA stating that she was going to punch the resident in the face. The administrator stated that he would speak with the resident regarding that allegation. No further information and/or documentation was presented prior to the exit conference on 03/21/19 to evidence that the facility staff implemented and followed policies and procedures for the prevention of abuse regarding an allegation of sexual abuse by Resident #8.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27353 Based on resident interview, staff interview, clinical record review and facility document review, the facility staff failed to report an allegation of sexual abuse to the state agency and/or officials in accordance with State law. Findings include: Resident #8 was admitted to the faintly on 05/30/17. Diagnoses for this resident included, but were not limited to: MS (multiple sclerosis), depression, anxiety, seizure disorder, bipolar disorder, neurogenic bladder, hypothyroidism, and hemiplegia. The most recent MDS (minimum data set) was an annual assessment dated [DATE]. This MDS documented the resident with a cognitive score of 13, indicating the resident was cognitively intact for daily decision making skills. This resident was assessed as requiring extensive assistance for most all ADLs (activities of daily living) with assistance of one staff and required total assistance for transfers and bathing with assistance of two staff. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/19 at 10:50 AM, Resident #8 was interviewed and stated that she had two complaints. The resident stated first, that an aide had stated to her that she was going to punch the resident in the face. The resident stated that she didn't know why the aide said that to her, but stated that maybe it was dominance and stated that the aide has continued working and providing care for her. The resident stated that she doesn't like to have this aide care for her due to what has happened in the past. The resident then stated that she was also sexually assaulted by those girls in the shower room, by 5 or 6 girls, including the girl that stated that she was going to punch her in the face. The resident stated that she had reported it to the administrator the following day and the incident happened on the 3-11 shift. The resident could not remember the date, but did state that it was about a month ago. The resident also stated that she also reported it to the SW (social worker). The resident called the administrator and SW by name, but stated that she did not remember the CNA's name (s) that assaulted her, but stated what she thought the name was. The resident again repeated that it was on the 3-11 shift and that she really didn't want to take a shower that day, but ended up going and that is what happened. The resident gave the name again for the CNA that she alleged was going to punch her in the face, which was also was one who was involved in the sexual assault (per the resident). The resident stated that she was not absolutely sure if that was her name, but it was something like that. The resident was asked if she went to the hospital after reporting that she was sexually assaulted, the resident stated, No. The resident was asked if anyone assessed or examined her after this was reported, the resident stated, No. The resident described the CNA by age, gender and race. The resident stated that she did not know how long the CNA has been at the facility, but stated .probably longer than me. The resident stated that the CNA works with her often. The resident stated that this incident happened about a month ago. The resident was asked what the administrator said to her when this was reported. The resident stated that when she reported that the CNA voiced punching her in the face, the administrator stated, we can't have that and that was about it. The resident stated that both incidences happened about a month ago and both were reported to the administrator and the SW. The resident was asked if the administrator asked for specific details. The resident stated that both the administrator and SW did talk to her and ask questions, but she didn't know if anything was written down. The resident stated that she could not remember what the SW had said to her about the incidences. The resident again stated that the CNA had been working her since it was reported. On 03/19/19 at 11:00 AM, the administrator was asked for any information regarding any allegations of abuse, complaints and/or concerns regarding this resident. The administrator was asked to check with the SW for any type of documentation or information regarding abuse or mistreatment for this resident. On 03/19/19 at 12:33 PM, the administrator presented a folder with a typed document from the DON (director of nursing). The administrator stated that he was aware of the alleged sexual assault and that this was the investigation (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation was presented and consisted of a folder, which contained one typed document by the DON. The information documented, 03/06/19 Insurance representative along with ED [executive director] came to my office r/t [related to] conversation she [sic] had with [name of resident] .reported to her [sic] that she was taken to the shower the prior evening and raped by 5 women .I was here on 03/05/19, at appox 2 PM .resident was sitting at the nurse's station after returning from an appointment .eczema looked considerably worse .asked the assigned CNA to shower her .[name of resident] did not want to take shower . but did agree .[name of CNA #1] with assistance of [name of CNA #2] completed .shower .put to bed . diagnoses of bipolar and anxiety .over the past months has become more confused .[name of resident] was drowsy, but able to put words together that made sensible sentences .asked .anything strange happened in the last couple of days .you heard about my shower .specifically what happened .a lot of women raped me . strange women .explained I needed more details .was not able to provide any .explained that CNA #1 gave her shower with assist of CNA #2 .and explained that what she is reporting is just not possible .you know me I probably dreamed it .starting to slur her words a little and was having a hard time keeping her eyes open. I told her I'd let her rest, to let staff know if she wanted to talk more later and I would come back at that time the conversation ended . No other information was provided regarding this incident. On 03/20/19 at 4:44 PM, the administrator and DON were made aware of concerns regarding this incident in a meeting with the survey team. The administrator stated that he knows his residents pretty well and felt like if he thought something like that had actually occurred he would have reported it. The administrator was made aware that this was an allegation of abuse and that abuse allegations are not only investigated or reported if the allegation actually happened. The administrator was made aware that this was an allegation of abuse made a resident of this facility. The DON and administrator both stated that this resident has been known to say things that weren't true. The administrator and DON were made aware that this was an allegation of abuse and should have been reported. The administrator stated, It was not a reported FRI [facility reported incident], but stated that he has since been educated. A policy on abuse was requested at this time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakhurst Health & Rehabilitation	4238 James Madson Highway Fork Union, VA 23055

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy Policies and Procedures Subject: Resident Abuse was presented and reviewed and documented the following: .policies and procedures to protect these rights to establish a disciplinary policy, which results in fair and timely treatment of occurrences of resident abuse .No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment .against any resident .abuse .physical abuse .verbal abuse .sexual abuse .neglect .questions may arise as to what actions constitute abuse of a resident. Any action that may cause actual physical, psychological or emotional harm .non-action, which results in emotional, psychological .all employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights .Any employee, who witnesses or has knowledge of an act of abuse or an allegation of abuse .is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator and to other officials in accordance with State law .An employee shall be deemed to have violated his obligations .if he does any of the following: fails to report an incident of abuse witnessed by or known .incomplete report of abuse .monitor residents at risk . all reported events .will be investigated .once an allegation of abuse is reported, the executive director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations .recognizes that preliminary reports of abuse can sometimes be clouded by biases and other factors that are relevant and need to be explored during a full investigation in order to obtain a clear picture of what actually happened .immediately upon an allegation of abuse or neglect, the suspect(s) shall be segregated from residents pending the investigation of the allegation .the clinical nurse in charge of director of clinical services shall perform and document a thorough nursing assessment and notify the attending physician .and incident report shall be filed .report the results .to the executive director .including to the State Survey Agency, within 5 working days . No further information and/or documentation was presented prior to the exit conference on 03/21/19 to evidence that the facility staff reported an allegation of sexual assault to the state agency or that the information was reported within the appropriate timeframe.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2019

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27353 Based on resident interview, staff interview, clinical record review and facility document review, the facility staff failed to thoroughly investigate an allegation of sexual abuse for one 19 residents in the survey sample, Resident #8. Findings include: Resident #8 was admitted to the faintly on 05/30/17. Diagnoses for this resident included, but were not limited to: MS (multiple sclerosis), depression, anxiety, seizure disorder, bipolar disorder, neurogenic bladder, hypothyroidism, and hemiplegia. The most recent MDS (minimum data set) was an annual assessment dated [DATE]. This MDS documented the resident with a cognitive score of 13, indicating the resident was cognitively intact for daily decision making skills. This resident was assessed as requiring extensive assistance for most all ADLs (activities of daily living) with assistance of one staff and required total assistance for transfers and bathing with assistance of two staff. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/19 at 10:50 AM, Resident #8 was interviewed and stated that she had two complaints. The resident stated first, that an aide had stated to her that she was going to punch the resident in the face. The resident stated that she didn't know why the aide said that to her, but stated that maybe it was dominance and stated that the aide has continued working and providing care for her. The resident stated that she doesn't like to have this aide care for her due to what has happened in the past. The resident then stated that she was also sexually assaulted by those girls in the shower room, by 5 or 6 girls, including the girl that stated that she was going to punch her in the face. The resident stated that she had reported it to the administrator the following day and the incident happened on the 3-11 shift. The resident could not remember the date, but did state that it was about a month ago. The resident also stated that she also reported it to the SW (social worker). The resident called the administrator and SW by name, but stated that she did not remember the CNA's name (s) that assaulted her, but stated what she thought the name was. The resident again repeated that it was on the 3-11 shift and that she really didn't want to take a shower that day, but ended up going and that is what happened. The resident gave the name again for the CNA that she alleged was going to punch her in the face, which was also was one who was involved in the sexual assault (per the resident). The resident stated that she was not absolutely sure if that was her name, but it was something like that. The resident was asked if she went to the hospital after reporting that she was sexually assaulted, the resident stated, No. The resident was asked if anyone assessed or examined her after this was reported, the resident stated, No. The resident described the CNA by age, gender and race. The resident stated that she did not know how long the CNA has been at the facility but stated .probably longer than me. The resident stated that the CNA works with her often. The resident stated that this incident happened about a month ago. The resident was asked what the administrator said to her when this was reported. The resident stated that when she reported that the CNA voiced punching her in the face, the administrator stated, we can't have that and that was about it. The resident stated that both incidences happened about a month ago and both were reported to the administrator and the SW. The resident was asked if the administrator asked for specific details. The resident stated that both the administrator and SW did talk to her and ask questions, but she didn't know if anything was written down. The resident stated that she could not remember what the SW had said to her about the incidences. The resident again stated that the CNA had been working her since it was reported. On 03/19/19 at 11:00 AM, the administrator was asked for any information regarding any allegations of abuse, complaints and/or concerns regarding this resident. The administrator was asked to check with the SW for any type of documentation or information regarding abuse or mistreatment for this resident. On 03/19/19 at 12:33 PM, the administrator presented a folder with a typed document from the DON (director of nursing). The administrator stated that he was aware of the alleged sexual assault and that this was the investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation was reviewed. The investigation folder contained one typed document by the DON. The information documented, 03/06/19 Insurance representative along with ED [executive director] came to my office r/t [related to] conversation she [sic] had with [name of resident] .reported to her [sic] that she was taken to the shower the prior evening and raped by 5 women .I was here on 03/05/19, at appox 2 PM . resident was sitting at the nurse's station after returning from an appointment .eczema looked considerably worse .asked the assigned CNA to shower her .[name of resident] did not want to take shower .but did agree .[name of CNA #1] with assistance of [name of CNA #2] completed .shower .put to bed .diagnoses of bipolar and anxiety .over the past months has become more confused .[name of resident] was drowsy, but able to put words together that made sensible sentences .asked .anything strange happened in the last couple of days .you heard about my shower .specifically what happened .a lot of women raped me .strange women . explained I needed more details .was not able to provide any .explained that CNA #1 gave her shower with assist of CNA #2 .explained that what she is reporting is just not possible .you know me I probably dreamed it .starting to slur her words a little and was having hard time keeping her eyes open. I told her I'd let her rest, to let staff know if she wanted to talk more later and I would come back at that time the conversation ended . No other information was provided regarding this incident. There were no employee statements. There was no information and/or documentation of any type of mental and/or physical assessment completed on this resident. The resident's CCP (comprehensive care plan) was reviewed and documented, .requires mechanical lift with 2 staff .totally dependent on staff for catheter/incontinence care .if exhibits behaviors (hypersexual conversation, request to speak to male staff members, suspicions of others, resistive to care, ask staff for money, paranoia, mood swings, states staff is outside of her room talking about her) make sure she is safe and re-approach later . On 03/20/19 at 4:44 PM, the administrator and DON were made aware of concerns regarding this incident in a meeting with the survey team. The administrator stated that he knows his residents pretty well and felt like if he thought something like that had actually occurred he would have reported it. The administrator was made aware at that this was an allegation of abuse and that this investigation did not include specific details and did not evidence that the resident was protected from abuse during the time of investigation. The DON and administrator both stated that this resident has been known to say things that weren't true. The administrator and DON were made aware that complete and thorough investigation was not completed for this resident regarding an allegation of sexual abuse. A policy on abuse was requested at this time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2019

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy Policies and Procedures Subject: Resident Abuse was presented and reviewed and documented the following: .policies and procedures to protect these rights to establish a disciplinary policy, which results in fair and timely treatment of occurrences of resident abuse .No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment .against any resident .abuse .physical abuse .verbal abuse .sexual abuse .neglect .questions may arise as to what actions constitute abuse of a resident. Any action that may cause actual physical, psychological or emotional harm .non-action, which results in emotional, psychological .all employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights .Any employee, who witnesses or has knowledge of an act of abuse or an allegation of abuse .is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator and to other officials in accordance with State law .An employee shall be deemed to have violated his obligations .if he does any of the following: fails to report an incident of abuse witnessed by or known .incomplete report of abuse .monitor residents at risk . all reported events .will be investigated .once an allegation of abuse is reported, the executive director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations .recognizes that preliminary reports of abuse can sometimes be clouded by biases and other factors that are relevant and need to be explored during a full investigation in order to obtain a clear picture of what actually happened .immediately upon an allegation of abuse or neglect, the suspect(s) shall be segregated from residents pending the investigation of the allegation .the clinical nurse in charge of director of clinical services shall perform and document a thorough nursing assessment and notify the attending physician .and incident report shall be filed .report the results .to the executive director .including to the State Survey Agency, within 5 working days . The resident's clinical record did not reveal any nursing notes, any type of mental and/or physical assessment had been completed for this resident as part of the investigation for an allegation of sexual assault. The SW (social worker) was interviewed on 03/21/19 at 9:45 AM. The SW stated that he had no knowledge of any sexual abuse allegations for Resident #8 until Tuesday (the day the survey team entered the facility), which was reported to him by the administrator. The SW stated that he had no knowledge of this resident alleging that a CNA was going to punch her in the face until last evening. No further information and/or documentation was presented prior to the exit conference on 03/21/19 to evidence that a complete and thorough investigation was completed for an allegation of sexual abuse by Resident #8.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview, facility document review and clinical record review, the facility staff failed to issue written notice of the bed-hold policy at the time of transfer for one of 19 residents in the survey sample. No written bed-hold notice was provided when Resident #109 was transferred to the hospital. The findings include: Resident #109 was admitted to the facility on [DATE] and was discharged to the hospital on 3/28/18. Diagnoses for Resident #109 included hip fracture, high blood pressure, peripheral vascular disease and diabetes. The minimum data set (MDS) dated [DATE] assessed Resident #109 with moderately impaired cognitive skills. Resident #109's clinical record documented the resident was sent to the emergency roiagnom on [DATE] due to an altered mental status. The clinical record documented no written notification to the resident or her responsible party concerning the bed-hold policy. On 3/21/19 at 10:30 a.m., the director of nursing (DON) was interviewed about any bed-hold notification for Resident #109 on 3/28/18. After searching the clinical record, the DON stated she did not find any bed-hold policy notification to Resident #109 or her representative at the time of transfer. The facility's policy titled Bed Hold (revised 11/1/17) documented, Resident or Resident Representative will be notified on admission, and at the time of transfer (to the hospital or therapeutic leave) of the bed hold policies, according to Federal and/or State requirements .At the time of transfer to the hospital or therapeutic leave, the center will provide a copy of notification of bed hold . This finding was reviewed with the administrator and director of nursing during a meeting on 3/21/19 at 4:50 p.m.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27353 Based on staff interview and clinical record review, the facility staff failed to ensure a PASARR (preadmission screening and resident review) was completed prior to admission to the facility for one of 19 residents in the survey sample, Resident 8. Findings include: Resident #8 was admitted to the faintly on 05/30/17. Diagnoses for this resident included, but were not limited to: MS (multiple sclerosis), depression, anxiety, seizure disorder, bipolar disorder, neurogenic bladder, hypothyroidism, and hemiplegia. The most recent MDS (minimum data set) was an annual assessment dated [DATE]. This MDS documented the resident with a cognitive score of 13, indicating the resident was cognitively intact for daily decision making skills. This resident was assessed as requiring extensive assistance for most all ADLs (activities of daily living) with assistance of one staff and required total assistance for transfers and bathing with assistance of two staff. During clinical record review for Resident #8, no preadmission screening of any kind could be located. On 03/19/19 at 3:00 PM, the Administrator and DON (director of nursing) were asked for the assistance in locating a PASARR for Resident #8. On 03/19/19 at 4:07 PM, the DON and administrator came in and presented an evaluation (not a PASARR). The DON was made aware that this was not a PASARR and was asked for a Level I PASARR, this would determine if a Level II was required. The DON stated, I know what a PASARR is. The DON stated that she would find it. On 03/20/19 at 8:50 AM, the administrator presented a PASARR for Resident #8. The PASARR was dated 03/19/19, completed the day before by the DON. The PASARR was not complete. The PASARR (Level I) question #5 was not completed to indicate if this resident was to be referred for a Level II or not. On 03/21/19 at 3:00 PM, the administrator and DON were made aware that the PASARR was not completed for this resident prior to admission and was completed on 03/19/19, but was still not complete. The PASARR did not answer the question whether the resident should or should not be referred for a Level II. No further information and/or documentation was presented prior to the exit conference on 03/21/19.

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NAME OF PROVIDER OR SUPPLIER Oakhurst Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4238 James Madson Highway Fork Union, VA 23055	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for three of 19 residents in the survey sample. 1. Resident #23 had no plan of care regarding use of plastic eating utensils due to unsafe behaviors. 2. Resident #29 had no individualized care plan developed regarding unsafe wandering and elopement prevention. 3. Resident #59 had no comprehensive plan of care regarding suicidal ideation. The findings include: 1. Resident #23 was admitted to the facility on [DATE] with a re-admission on [DATE]. Diagnoses for Resident #23 included dementia, dysphasia, high blood pressure and history of hip fracture. The minimum data set (MDS) dated [DATE] assessed Resident #23 with severely impaired cognitive skills. On [DATE] at 12:30 p.m., Resident #23 was observed eating lunch in her room. The resident was using plastic utensils while eating. The meal ticket on Resident #23's lunch tray documented, Plastic Silverware. Resident #23's clinical record documented a dietary slip dated [DATE] stating, Please only give plastic utensils. Resident #23's plan of care (dated [DATE]) included no problems, goals and/or interventions regarding the use of plastic utensils. The care plan listed the resident had paranoid behaviors, aggression and was at times physically abusive to staff. Interventions to minimize behaviors made no mention of plastic eating utensils. This plan of care listed the resident had potential for nutritional problems due to dementia but made no mention of the use of plastic utensils. On [DATE] at 8:07 a.m., the dietary manager was interviewed about plastic utensils provided for Resident #23. The dietary manager stated the resident was not safe to have the standard, stainless utensils. The dietary manager stated Resident #23 had attempted to pry towel racks from the wall and had been aggressive with staff using the standard silverware. On [DATE] at 8:10 a.m., the licensed practical nurse (LPN #2) caring for Resident #23 was interviewed about the plastic utensils. LPN #2 stated the resident about a year ago tried to stab staff members with the knife from her meal tray. LPN #2 stated the resident also attempted to pry room items with the standard utensils. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 8:15 a.m., LPN #3 responsible for care plan development was interviewed about Resident #23. LPN #3 reviewed the care plan and stated she did not see anything on the plan regarding the plastic utensils. LPN #3 stated she was not aware the resident used plastic utensils and did not recall discussing plastic utensils during the last care plan review. These findings were reviewed with the administrator and director of nursing during a meeting on [DATE] at 4:50 p.m. 40027 2. Resident #29 was admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included sepsis, type 2 diabetes, hypertension, malnutrition, acute gastritis, stage IV pressure wound, multifactoria dementia, deafness requiring cochlear implant, hepatitis C, and chronic obstructive pulmonary disease (COPD). The most recent minimum data set (MDS) dated [DATE], a quarterly assessment, assessed Resident #29 as being severely cognitively impaired with a score of 03 out of 15 for daily decision making. The state agency received 2 facility reported incidents (FRI) regarding Resident #29 being found outside. The first FRI was dated [DATE] documented the following: [Resident #29] was found on ground, outside, beside wheelchair. Resident sent to hospital via 911. The second FRI was dated [DATE]. On [DATE], Resident #29's clinical record was reviewed. An readmission assessment was completed on [DATE] at 17:30 p.m. and documented the following under the elopement risk evaluation: 1. Is resident cognitively impaired? Response: Yes 2. Is resident independently mobile (ambulatory or wheelchair)? Response: Yes 3. Does resident have poor decision making skills? Response: Yes 4. Has resident demonstrated exit-seeking behaviors? Response: Yes 5. Does resident wander oblivious to safety needs? Response: Yes 6. Does resident have a a history of elopement? If yes, # of times, if known ___ (left blank). Response: Yes 7. Does resident have the ability to exit the facility? Response: Yes The elopement risk evaluation documented the following: YES to questions 4, 5, or 6 automatically place the resident AT RISK. Based on potential risk factors above, resident is determined to be AT RISK for elopement. Response: Yes .If it is determined that the resident has eloped, implement care plan immediately to ensure resident's safety. Report all residents AT RISK to the Director of Clinical Services and on the 24-Hour Report. Resident #29's care plan which were in place at the time of the readmission [DATE] were reviewed and documented the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: [Resident #29] has inappropriate behaviors. AEB (as evidenced by) sexually inappropriate behavior, other behaviors include hitting, refusing care, yelling, attempt to elope. Date initiated [DATE]. Revision on [DATE]. Goals: [Resident #29] will not display inappropriate sexual behaviors towards staff through next review. Date initiated: [DATE]. Revision on [DATE]. Interventions: Wander Guard protocol. Date initiated [DATE]. Revision on [DATE]. There were no person centered interventions regarding elopement risk or supervision. The intervention for wander guard protocol was not initiated until [DATE], after the elopement risk assessment on [DATE] which documented Resident #29 as at risk for elopement, and after the resident was found outside with injury on [DATE]. On [DATE] at 10:30 a.m., the director of nursing (DON) was interviewed regarding the lack of person centered interventions regarding Resident #29 for elopement risk, wandering and supervision. The DON stated Resident #29 had always been allowed to go outside unsupervised as the facility had a discussion with his sister about letting him go outside because he enjoyed the sunny weather. The DON stated Resident #29 was safe to be outside alone and he would let himself in/out of the patio door. The DON was interviewed regarding the re-admission assessment on [DATE] which assessed Resident #29 as an elopement risk. The DON stated Resident #29 was an elopement risk, however, at the time of the assessment he had not tried to elope. The DON was asked to review the care plan which was initiated on [DATE] with a focus area documenting Resident #29's behaviors that included attempted to elope. The DON stated the nurse who completed the readmission assessment on [DATE] was no longer employed at the facility and there should have been a care plan to address the elopement, wandering and supervision. The DON stated she did update the care plan to include the wander guard after the [DATE] incident when Resident #29 was found outside alone on the ground. These findings were discussed during a meeting on [DATE] at 4:50 p.m., with the Administrator, Director of Nursing and Nurse Consultant. 27353 3. Resident #59 admitted to the facility on [DATE]. Diagnoses included, but were not limited to: anemia, thyroid disorder, osteoarthritis, MS (multiple sclerosis), anxiety disorder, depression, neuralgia, neuritis, chronic pain syndrome, intractable migraines, and opioid abuse. An annual MDS (minimum data set) dated [DATE] documented the resident was a score of 15 for cognition, indicating the resident was cognitively intact for daily decision making skills. The resident was documented with a score of 23 [range ,d+[DATE]] for total severity of mood and was also assessed on this MDS as having potential for self harm. The resident was extensive assist with most ADLs (activities of daily living) with at least one person assist. The resident triggered for cognition, ADL function, urinary, mood, psychosocial, behavior, falls, nutrition, psychotropic drug use, and pain in the CAAS (care area assessment summary) section of this MDS. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2019
NAME OF PROVIDER OR SUPPLIER Oakhurst Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4238 James Madson Highway Fork Union, VA 23055	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly assessment dated [DATE] was reviewed and documented the resident's cognitive score of 15 (intact for daily decision making skills) and the total mood score was 20. A significant change assessment dated [DATE] documented the resident with a cognitive score of 15 indicating the resident was intact for daily decision making skills. The total severity score for mood on this MDS was scored 16. The resident was also documented as having delusions and verbal behaviors toward others, with the presence of overall behavioral symptoms as worse. The resident was assessed as requiring limited assistance with at least one person assist for most ADLs (physical improvement from last MDS assessment). A complaint investigation was completed on Resident #59 on [DATE] through [DATE]. An allegation within the complaint alleged that Resident #59 injured self ([DATE]) with a disposable razor that was not a facility issued item, 911 was called and the resident was taken to the hospital and then readmitted back to the facility on [DATE]. Resident #59's closed clinical records were reviewed. The resident's physician order sheet and interim plan of care dated [DATE] (original admission) was reviewed and documented, the resident as having .vitamin B 12 deficiency, opioid abuse, MS, migraines, GERD, anxiety, major depressive disorder, hypothyroidism, chronic pain syndrome, osteoporosis, neuralgia and neuritis. The treatment/care plan was to: adjust to nursing facility placement for long term care .regular diet .may participate in activity and general conditioning program as desired, may attend religious and social activities without limitations or precautions unless otherwise notes . The resident's POS (Physician order set) for [DATE] through [DATE] were reviewed and documented, .CPR . Regular mechanical soft diet .PAPER PLATES AND PLASTIC UTENSILS ONLY .bed against the wall . A review of the clinical record revealed one psychiatric consult dated [DATE]. This consult documented, . seen evaluated .follow up depression last seen Nov. 2017 .today she looks much brighter than at previous visits . sleep: ok food: if you can call it food! .sitting up in bed .pleasant and cooperative with good eye contact .MOOD: 'This isn't any way to live' .looks brighter today .continue current meds. if depression symptoms persist, could increase .[wellbutrin 150 mg ER] to BID .can also consider trial of [effexor XR] in lieu of [zoloft] .discuss pt status with POA .signature of psychiatry/neurobehavioral services. On [DATE] at 9:45 AM, the SW (social worker) was interviewed regarding Resident #59. The SW was asked about the MDS information for this resident. The SW stated that if a resident answers the last question in that section with yes, then that triggers a response for the following question which asked if staff or provider were informed that there is a potential for resident self harm. The SW stated that is why that is marked yes, indicating that staff and/or the provider were made aware of this information. The SW was asked if this information should be care planned for the resident. The SW stated that it should be and thought it was for this resident. The SW was asked for the CAAS (care area assessment summary) worksheets for mood and behavior for the MDS assessments. The SW presented CAAS worksheet for the annual MDS assessment and for the significant change MDS assessment. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakhurst Health & Rehabilitation	4238 James Madson Highway Fork Union, VA 23055

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CAAS worksheet dated [DATE] documented, .psychosocial well being .The resident has a actual problem .often declines activities .depression .decline in ADL's .Mood or behavior problem that impacts interpersonal relationships .falls, pain .care planning for this problem, what is the overall objective: improvement .Describe impact of this problem .include complications and risk factors and the need for referral to other health professionals: Is a referral to another discipline warranted? No .Mood State: Resident has had thoughts that he/she would be better off dead, or thoughts of hurting him/herself as indicated by: Thoughts that you would be better off dead, or of hurting yourself in some way .yes .Analysis of Findings: has a actual problem with feeling hopeless .reported that at times she feels that she would be better off dead due to her illness .Relapse of an underlying mental health problem .Psychiatric disorder, anxiety, depression, manic depression .pain .mental health and health issues contribute to thoughts of not living. The resident is often observed throughout the day in bed in and out of sleep .Mood State- care planning for this problem, what is the overall objective: improvement Behavioral Symptoms .has a actual problem with rejecting ADL care .needs several prompts and encouragement from staff for bathing and dressing .Seriousness of the behavioral symptoms: Resident is immediate threat to self - IMMEDIATE INTERVENTION REQUIRED . Resident's behavior status, care rejection, or wandering has worsened since last assessment .At times the resident has thoughts of being better off dead. The resident has a dx [diagnosis] of MS which contributes to feelings of hopelessness, stressed that she gets sad when she thinks about being 'crippled up in the bed' . Care plan consideration Will behavioral symptoms- functional status be addressed in the care plan? Yes . Improvement .Referral to Other Disciplines: Is a referral to another discipline warranted? No . The CAAS worksheet dated [DATE] documented, .psychosocial well being .verbal behavioral symptoms . actual problem with verbal behavior when she is unable to get her way .curses and calls staff names .has thrown food tray on the floor and thrown objects Depression .Mood or behavior problem that impacts interpersonal relationships .overall objective: improvement .minimize risks .Describe impact of this problem . include complications and risk factors .Is a referral to another discipline warranted? No .Mood State: has actual problem with regulating her mood .depression and anxiety .stressed that the pain caused by her MS and inability to walk makes her sad .Delusions .antipsychotics .improvement, slow or minimize decline . minimize risks .Care plan consideration Will Mood State- functional status be addressed in the care plan? Yes .Improvement .Is a referral to another discipline warranted? No .Referral: No . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's CCP (comprehensive care plan) was reviewed prior to self harm incident ([DATE]) and documented, .is dependent on staff for activities, cognitive stimulation, social interaction .engage in activities . explain the importance of social interaction, encourage participation .in room visits .music .provide a calm non rushed environment .reality orientation .report c/o [complaints of] pain, discomfort .or any other c/o that interferes with resident's ability to participate .to the nurse .needs assistance/escort to and from activity . impulsive behavior .history of throwing glass plates when she becomes upset .psychotropic med use . adaptive equipment .walker/wheelchair .anticipate and meet the residents needs .keep needed items .in reach .medication as ordered .[name of resident] needs a safe environment .Resident to received plastic silverware and Styrofoam plates/bowls for all meals .keep call bell in within easy reach .medication as per physician order .monitor and report restlessness, agitation, confusion .monitor and report to MD [medical doctor] s/sx [signs and symptoms] of depression. Obtain order for mental health consult if needed .monitor and report medication side effects and effectiveness every shift .ADL-Observe skin for redness, open areas, scratches, cuts, bruises and report changes to nurse .bathing: provide resident with a sponge bath when a shower can not be tolerated .provide the resident with assistance to bathe daily and as needed .psychoactive use .antidepressant .depression .antipsychotic .depression .antianxiety .anxiety/agitation . non drug interventions- monitor behavioral symptoms and side effects such as appetite changes, memory impairment . antidepressants: report .signs and symptoms of depression or problematic side effects to practitioner . antipsychotic- monitor behavioral symptoms . evaluate medication response and resident's response quarterly .if side effect present report to practitioner .medication as ordered .non drug interventions-see behavior care plan .educate patient .on consequences of poor behavior choices/non compliance .encourage group activities .encourage resident to express feelings .monitor for increase in behaviors or unsafe behaviors and report to physician as needed .impaired thought processes .monitor and report to MD any changes in cognitive function, specifically changes in decision making ability, memory, recall, and general awareness .distress of yelling out when she is not due for pain medications, emotional distress .throwing items and cursing staff and c/o chronic unrelieved pain .anticipate the resident's need for pain relief .assess coping strategies .attempt non pharmacological interventions .distraction .express feelings .monitor and report to nurse resident complaints of pain or requests for pain treatment .monitor and report to .nurse . mood/behavior changes, more irritable, restless, aggressive, squirmy, constant motion .psych consult as needed . No information and/or documentation regarding the resident's thoughts of death or thoughts/risks of self harm were found anywhere on the resident's CCP. The nursing notes were reviewed for this resident for 2018. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note dated [DATE] (no time stamp) documented, At approximately 10 AM this writer was alerted to the front lobby where I was met by a police officer, patient had called 911 stated that she was ringing her call light since 8:15 with no answer. Escort police officer X 3 to patients room patient stated that she had migraine [sic] and nurse would not provide me [sic] with medications for my migraine this nurse offered PRN [as needed] Zomig - schedule excedrine patient refused stated, 'your not a nurse your uneducated go back to school, I'm gonna sue the doctor for malpractice police officer talked with patient to .while offered to send patient to ER [emergency room] patient refused MD notified no new medication order per MD narcotic not appropriate for migraines - patient had requested 'strong' pain medication patient refused am medications - prior to police arrival patient had thrown tray across room when asked why she stated 'I can't eat that' per CNA [certified nursing assistant] statement she had placed breakfast tray in at approximately 8:00 AM and had been in room X 2 between then and 9:30 and nurse (LPN) stated that she had also been in patients room between those times patient aware of no new medications patient told this RN to get out of my room again stated that she was going to sue the MD no further behaviors this shift . [DATE] at 3:45 PM staff reported resident requested to see nurse this nurse responded immediately to find resident cutting L [left] wrist inner with shaving razor this nurse repeatedly asked resident to stop she stated 'no I want morphine' this nurse removed razor from resident and applied towel with pressure to L inner wrist resident attempted to kick this writer yelling 'I have to wait 20 more minutes before I can have my medicine and I don't want to wait' staff stayed 1:1 with resident while this nurse called 911 for transport to ED [emergency department], ADON [assistant director of nursing], notified immediately of incident, MD notified . On [DATE] at approximately 11:30 AM, the administrator, DON and corporate nurse were made aware of serious concerns with Resident #59 in a meeting with the survey team. The facility staff were made aware of the lack of interventions and/or services provided to prevent accidents/self harm for this resident. The facility staff were made aware that this resident had been identified by facility staff as a high risk for self harm in May of 2018, as documented above, and no new interventions were developed and/or implemented for the prevention of accidents, the resident's CCP did not address these concerns. The resident's discharge summary from the hospital dated [DATE] documented, .Admission Primary diagnosis: Status migrainous, intractable and suicidal ideation .history notable for multiple sclerosis, chronic migraines, depression COPD, opioid use disorder and suicide attempt due to medication overdose who presented to the ED after attempted suicide .onset of a migraine 2 weeks ago .she reports she has not been sleeping for months. She says the pain was so bad that she decided to cut her wrist .she continues to endorse active suicidal ideation .she attributed her suicidal ideation to her intractable severe migraines. Psychiatry evaluated the patient and felt her presentation was consistent with an adjustment disorder with mixed disturbance of emotions and conduct .she denied suicidal ideation when reevaluated by psychiatry on [DATE] .cleared for discharge back to her skilled nursing facility .ambulatory referral to [name of psychiatrist] or .may continue to follow with the psychiatrist's at the SNF. No further information and/or documentation was presented prior to the exit conference on [DATE] at 6:15 PM to evidence the facility staff developed and/or implemented interventions for the prevention of self harm for Resident #59, after the resident had been identified as having a high mood score and as being identified as a risk for self harm. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	THIS IS A COMPLAINT DEFICIENCY.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40027 Based on clinical record review and staff interview, the facility failed to review and revise a comprehensive care plan for one of nineteen residents. Resident #20's care plan was not revised regarding code status. The findings include: Resident #20 was admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included eczema, bursitis of hip, perforated appendicitis, muscle weakness, chronic bronchitis, dementia with behaviors, depression, hypertension and anorexia. The most recent minimum data set (MDS) dated [DATE], was a significant change and assessed Resident #20 as severely cognitively impaired with a score of 01 out of 15 for daily decision making. Resident #20's clinical record was reviewed on 03/20/18 at 10:00 a.m. Observed on the physician's order form were orders for Do Not Resuscitate - Do Not Intubate, dated 12/22/18. Resident 20's care plans were reviewed and documented the following: Focus - [Resident #20], has advance directives r/t (related to) his choice not to execute advance directives. [Resident #20] is a full code. Date Initiated: 11/28/2018. Created by: [Social Worker]. On 03/21/19 at 9:43 a.m., the social services director (OS #3) was interviewed regarding Resident #20's code status care plan. OS #3 stated Resident #20 code status is currently a DNR (do not resuscitate). OS #3 stated he updates the care plans as soon as he is notified of any changes. OS #3 stated when the code status change was made in December he changed it on his audit sheet, but he never updated the care plan. He stated it was just an oversight. These findings were discussed during a meeting on 03/21/19 at 4:50 p.m., with the Administrator, Director of Nursing and Nurse Consultant.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27353 Based on resident interview, clinical record review and staff interview, the facility staff failed to implement a bowel regimen program for one of 19 residents in the survey sample, Resident #26. Resident #26 stated that he had not had a bowel movement in 5 days and was uncomfortable. Findings include: Resident # 26 was admitted to the facility on [DATE]. Diagnoses for Resident #26 included, but were not limited to: atrial fibrillation, high blood pressure, anxiety disorder and depression. The most recent MDS (minimum data set) was a 14 day admission assessment dated [DATE]. This MDS documented the resident with a cognitive score of 14, indicating the resident was cognitively intact for daily decision making skills. The resident also was assessed as requiring supervision with one person physical assist for most all ADL's except bathing, which was extensive assist of person. He was coded a 0 (always continent) for bowel and 1 for urinary (occasional incontinent). On 03/20/19 at approximately 2:30 PM, the resident stated to this surveyor that he had not had a BM (bowel movement) in 5 days and was having problems and he needed help. The resident stated that he needed a suppository and that would help him, but for some reason the staff would not give him one. The resident stated that he had this problem about a month ago, ended up straining to go to the bathroom and went to the hospital for chest pain. Resident #26's clinical records were reviewed and revealed the resident had current orders for Colace 100 mg (milligrams) two caps by mouth once daily for bowel aid, and also a current order for Miralax 17 grams once every day for constipation. The resident's current CCP (comprehensive care plan) documented, .Toilet Use: [name of resident] is able to toilet himself independently/with supervision of staff .notify nursing of incontinent episodes .unobstructed path to bathroom . The resident's MARS (medication administration records) were reviewed and revealed documentation that the above medications were administered per physician's orders. The resident's bowel records were then reviewed for February and March 2019. The resident's bowel records for February documented that Resident #26 did not have a bowel movement for 10 days. During this 10 period there were several blank boxes that did not document anything for this resident regarding a BM. The March 2019 bowel records were then reviewed and documented that the resident went 5 days without a BM. During this time frame, two days were completely blank. Additionally in March it was documented that the resident had not had BM for 8 days (this is the time frame the Resident stated no BM for 5 days); for this time period there were two days without any documentation to reveal if the resident had a BM or not. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/20/19 at 10:13 AM, Resident #26 was interviewed. The resident stated that the facility staff finally gave him a suppository yesterday. The resident stated that he did have a BM as result of the suppository and felt better. The resident stated that he gets like that sometimes and he knows what works for him, but feels the staff don't listen. The resident stated that he has a heart condition (atrial fibrillation) and is not supposed to be straining to go to the bathroom. The resident stated that he has had this problem for a long time and is not new. The resident stated that he will tell the staff whether or not he has a BM, if staff ask. The resident then stated if they don't ask, he doesn't always remember to tell them. The resident then stated that, If I go to them and tell them I haven't had a BM, then I haven't had one. The resident stated that they wanted to do things their way. The DON (director of nursing) and administrator were made aware in a meeting with the survey team on 03/20/19 at approximately 3:00 PM of the resident's concerns and documented bowel records. A bowel protocol was requested at this time. The DON stated that this resident can become obsessed with his bowels and further stated that there are blanks on the bowel records. The DON was made aware that this resident is alert and oriented and perfectly capable of knowing when he has had a BM or not and is able to communicate that to nursing staff if the resident is asked. On 03/21/19 at approximately 11:00 AM, the DON presented a BM worksheet. This worksheet documented, . is filled in by nursing assistant each shift .is kept at the desk on a clipboard .accessible to the nursing assistant .Do not leave a blank space .the BM worksheet .identifies the need for additional interventions .If the resident has not had a BM by the third day, he/she is given a laxative or suppository, depending upon the circumstance and physician orders. The nurse checks the resident's order sheet making sure there is laxative or suppository order. The DON stated that, if there is no BM in 3 days, we will use a PRN (as needed) order that is already ordered or notify the physician for the need for an order. The DON stated that this resident has current orders, but does not have a PRN and stated that there are no standing orders that can be used. The DON stated that the resident got a one time order yesterday for the suppository. No further information and/or documentation was presented prior to the exit conference on 03/21/19 at 6:15 PM to evidence that the facility's Bowel Protocol was implemented for Resident #26.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27353 Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation, the facility staff failed to ensure supervision for the prevention of accidents for one of 19 residents in the survey sample, Resident #29. Resident #29, assessed as an elopement risk was not provided supervision and found outside of the facility on [DATE] and [DATE]. Findings include: Resident #59 admitted to the facility on [DATE]. Diagnoses included, but were not limited to: anemia, thyroid disorder, osteoarthritis, MS (multiple sclerosis), anxiety disorder, depression, neuralgia, neuritis, chronic pain syndrome, intractable migraines, and opioid abuse. An annual MDS (minimum data set) dated [DATE] documented the resident was a score of 15 for cognition, indicating the resident was cognitively intact for daily decision making skills. The resident was documented with a score of 23 [range ,d+[DATE]] for total severity of mood and was also assessed on this MDS as having potential for self harm. The resident was extensive assist with most ADLs (activities of daily living) with at least one person assist. The resident triggered for cognition, ADL function, urinary, mood, psychosocial, behavior, falls, nutrition, psychotropic drug use, and pain in the CAAS (care area assessment summary) section of this MDS. A quarterly assessment dated [DATE] was reviewed and documented the resident's cognitive score of 15 (intact for daily decision making skills) and the resident's total mood score was 20, still a high score of depressed mood. Section: D03050. Safety Notification: was blank. A significant change assessment dated [DATE] documented the resident with a cognitive score of 15 indicating the resident was intact for daily decision making skills. The total severity score for mood on this MDS was scored 16. The resident was also documented as having delusions and verbal behaviors toward others, with the presence of overall behavioral symptoms as worse. The resident was assessed as requiring limited assistance with at least one person assist for most ADLs (physical improvement from last MDS assessment). A complaint investigation was completed on Resident #59 on [DATE] through [DATE]. An allegation within the complaint alleged that Resident #59 injured self ([DATE]) with a disposable razor that was not a facility issued item, 911 was called and the resident was taken to the hospital and then readmitted back to the facility on [DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #59's closed clinical records were reviewed. The resident's physician order sheet and interim plan of care dated [DATE] (original admission) was reviewed and documented, the resident as having .vitamin B 12 deficiency, opioid abuse, MS, migraines, GERD, anxiety, major depressive disorder, hypothyroidism, chronic pain syndrome, osteoporosis, neuralgia and neuritis. The treatment/care plan was to: adjust to nursing facility placement for long term care .regular diet .may participate in activity and general conditioning program as desired, may attend religious and social activities without limitations or precautions unless otherwise notes . The resident's POS (Physician order set) for [DATE] through [DATE] was reviewed and documented, .CPR . Regular mechanical soft diet .PAPER PLATES AND PLASTIC UTENSILS ONLY .bed against the wall . No orders for psychiatric services were found. A review of the clinical record revealed one psychiatric consult dated [DATE]. This consult documented, . seen evaluated .follow up depression last seen Nov. 2017 .today she looks much brighter than at previous visits . sleep: ok food: if you can call it food! .sitting up in bed .pleasant and cooperative with good eye contact .MOOD: 'This isn't any way to live' .looks brighter today .continue current meds. if depression symptoms persist, could increase .[wellbutrin 150 mg ER] to BID .can also consider trial of [effexor XR] in lieu of [zoloft] .discuss pt status with POA .signature of psychiatry/neurobehavioral services. The resident's physician's orders were reviewed from ,d+[DATE] through ,d+[DATE] and did not reveal either of the recommendations were implemented during this time. On [DATE] at approximately 9:00 AM, the administrator was asked for the investigation regarding Resident #59's self harm. On [DATE] at 9:45 AM, the SW was interviewed regarding Resident #59. The SW was asked about the MDS information for this resident. The SW stated that he completes sections C [cognitive patterns], D [Mood], and E [behavior] on the MDS. The SW was asked about Resident #59's annual MDS assessment dated May of 2018, specifically regarding the resident's high mood score along with documented concerns for self harm. The SW stated that if a resident answers the last question in that section with yes, then that triggers a response for the following self harm question which asked if there is a potential for resident self harm. The SW stated that is why that is marked yes, indicating knowledge of staff and/or the provider of potential for self harm regarding this resident. The SW was asked about the quarterly assessment in July (Mood Score 20) and the significant change assessment in August (Mood Score 16). The SW stated that the resident still had a high mood score, but did not voice hurting herself on those. The SW was asked if this type of information (self harm) should be care planned for the resident. The SW stated that it should be and thought it was for Resident #59. The SW was asked for the CAAS (care area assessment summary) worksheets for mood and behavior for the MDS assessments. The SW presented CAAS worksheet for the annual MDS assessment and for the significant change MDS assessment. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Oakhurst Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4238 James Madson Highway Fork Union, VA 23055	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CAAS worksheet dated [DATE] documented, .psychosocial well being .The resident has a actual problem .often declines activities .depression .decline in ADL's .Mood or behavior problem that impacts interpersonal relationships .falls, pain .care planning for this problem, what is the overall objective: improvement .Describe impact of this problem .include complications and risk factors and the need for referral to other health professionals: Is a referral to another discipline warranted? No .Mood State: Resident has had thoughts that he/she would be better off dead, or thoughts of hurting him/herself as indicated by: Thoughts that you would be better off dead, or of hurting yourself in some way .yes .Analysis of Findings: has a actual problem with feeling hopeless .reported that at times she feels that she would be better off dead due to her illness .Relapse of an underlying mental health problem .Psychiatric disorder, anxiety, depression, manic depression .pain .mental health and health issues contribute to thoughts of not living. The resident is often observed throughout the day in bed in and out of sleep .Mood State- care planning for this problem, what is the overall objective: improvement Behavioral Symptoms .has a actual problem with rejecting ADL care .needs several prompts and encouragement from staff for bathing and dressing .Seriousness of the behavioral symptoms: Resident is immediate threat to self - IMMEDIATE INTERVENTION REQUIRED . Resident's behavior status, care rejection, or wandering has worsened since last assessment .At times the resident has thoughts of being better off dead. The resident has a dx [diagnosis] of MS which contributes to feelings of hopelessness, stressed that she gets sad when she thinks about being 'crippled up in the bed' . Care plan consideration Will behavioral symptoms- functional status be addressed in the care plan? Yes . Improvement .Referral to Other Disciplines: Is a referral to another discipline warranted? No . The CAAS worksheet dated [DATE] documented, .psychosocial well being .verbal behavioral symptoms . actual problem with verbal behavior when she is unable to get her way .curses and calls staff names .has thrown food tray on the floor and thrown objects Depression .Mood or behavior problem that impacts interpersonal relationships .overall objective: improvement .minimize risks .Describe impact of this problem . include complications and risk factors .Is a referral to another discipline warranted? No .Mood State: has actual problem with regulating her mood .depression and anxiety .stressed that the pain caused by her MS and inability to walk makes her sad .Delusions .antipsychotics .improvement, slow or minimize decline . minimize risks .Care plan consideration Will Mood State- functional status be addressed in the care plan? Yes .Improvement .Is a referral to another discipline warranted? No .Referral: No . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's CCP (comprehensive care plan) was reviewed prior to self harm incident ([DATE]) and documented, .is dependent on staff for activities, cognitive stimulation, social interaction .engage in activities . explain the importance of social interaction, encourage participation .in room visits .music .provide a calm non rushed environment .reality orientation .report c/o [complaints of] pain, discomfort .or any other c/o that interferes with resident's ability to participate .to the nurse .needs assistance/escort to and from activity . impulsive behavior .history of throwing glass plates when she becomes upset .psychotropic med use . adaptive equipment .walker/wheelchair .anticipate and meet the residents needs .keep needed items .in reach .medication as ordered .[name of resident] needs a safe environment .Resident to received plastic silverware and Styrofoam plates/bowls for all meals .keep call bell in within easy reach .medication as per physician order .monitor and report restlessness, agitation, confusion .monitor and report to MD [medical doctor] s/sx [signs and symptoms] of depression. Obtain order for mental health consult if needed .monitor and report medication side effects and effectiveness every shift .ADL-Observe skin for redness, open areas, scratches, cuts, bruises and report changes to nurse .bathing: provide resident with a sponge bath when a shower can not be tolerated .provide the resident with assistance to bathe daily and as needed .psychoactive use .antidepressant .depression .antipsychotic .depression .antianxiety .anxiety/agitation . non drug interventions- monitor behavioral symptoms and side effects such as appetite changes, memory impairment . antidepressants: report .signs and symptoms of depression or problematic side effects to practitioner . antipsychotic- monitor behavioral symptoms . evaluate medication response and resident's response quarterly .if side effect present report to practitioner .medication as ordered .non drug interventions-see behavior care plan .educate patient .on consequences of poor behavior choices/non compliance .encourage group activities .encourage resident to express feelings .monitor for increase in behaviors or unsafe behaviors and report to physician as needed .impaired thought processes .monitor and report to MD any changes in cognitive function, specifically changes in decision making ability, memory, recall, and general awareness .distress of yelling out when she is not due for pain medications, emotional distress .throwing items and cursing staff and c/o chronic unrelieved pain .anticipate the resident's need for pain relief .assess coping strategies .attempt non pharmacological interventions .distraction .express feelings .monitor and report to nurse resident complaints of pain or requests for pain treatment .monitor and report to .nurse . mood/behavior changes, more irritable, restless, aggressive, squirmy, constant motion .psych consult as needed . No information was on the resident's CCP regarding any self harm, or statements of the resident stating, being better off dead', and there were no interventions to address these identified concerns. None of the information from the above MDS and/or CAAS Worksheets regarding this resident's risk for self harm was incorporated in any way into the resident's CCP. The progress and nursing notes were reviewed for this resident for 2018 and included the following: A progress note dated [DATE] documented, .continues to display inappropriate behaviors at times, she throws her food tray and other objects on the floor when she is unable to get her way, when upset .verbally abuses staff by cursing and calls them names based on skin color .prefers to lay in bed most of the day, struggles with staying safe .has had a few falls .signature of [social worker]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated [DATE] documented, .threw food tray full of food onto floor, when given medications she throw back [sic] at nurse .attempted to pinch/punch and bite nurse and CNA that was assisting back into her w/c. [name of resident] propels to the nursing station and made allegations of sexual assault .[name of resident] started chasing female nurse in w/c which led to the sheriff department being called .investigate allegations of sexual assault .[name of resident] she struggle with [sic] recalling the behavior she displayed and stated she never said anybody sexually assaulted her .new med order for Ativan 1 mg will continue to monitor .SW A progress note dated [DATE] documented, Significant change .alert and oriented with some forgetfulness/confusion is able to recognize some staff by name, able to make needs known all needs met by nursing .often observed in bedroom by choice, this is often due to depression .Significant change due to ongoing behavior issues .SW A nursing note dated [DATE] documented, resident came out of room and demanded Tylenol. she then made rude statements and became agitated. Redirecting her didn't help .made paranoid statements about the Tylenol .went back to room and then came back out and accused us [staff] of removing pictures from her room . A nursing note dated [DATE] (no time stamp) documented, At approximately 10 AM this writer was alerted to the front lobby where I was met by a police officer, patient had called 911 stated that she was ringing her call light since 8:15 with no answer. Escort police officer X 3 to patients room patient stated that she had migraine [sic] and nurse would not provide me [sic] with medications for my migraine this nurse offered PRN [as needed] Zomig - schedule excedrine patient refused stated, 'your not a nurse your uneducated go back to school, I'm gonna sue the doctor for malpractice police officer talked with patient to .while offered to send patient to ER [emergency room] patient refused MD notified no new medication order per MD narcotic not appropriate for migraines - patient had requested 'strong' pain medication patient refused am medications - prior to police arrival patient had thrown tray across room when asked why she stated 'I can't eat that' per CNA [certified nursing assistant] statement she had placed breakfast tray in at approximately 8:00 AM and had been in room X 2 between then and 9:30 and nurse (LPN) stated that she had also been in patients room between those times patient aware of no new medications patient told this RN to get out of my room again stated that she was going to sue the MD no further behaviors this shift . A nursing note dated [DATE] at 3:45 PM documented staff reported resident requested to see nurse this nurse responded immediately to find resident cutting L [left] wrist inner with shaving razor this nurse repeatedly asked resident to stop she stated 'no I want morphine' this nurse removed razor from resident and applied towel with pressure to L inner wrist resident attempted to kick this writer yelling 'I have to wait 20 more minutes before I can have my medicine and I don't want to wait staff stayed 1:1 with resident while this nurse called 911 for transport to ED [emergency department], ADON [assistant director of nursing], notified immediately of incident, MD notified . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at approximately 11:30 AM, the administrator, DON and corporate nurse were made aware of serious concerns with Resident #59 in a meeting with the survey team. The facility staff were made aware of the lack of interventions and/or services provided to prevent accidents/self harm for this resident. The facility staff were made aware that this resident had been identified by facility staff as having a high mood score for depression and as being a risk for self harm in May of 2018, with no interventions developed or implemented for the prevention of accidents/self harm for this resident. The staff were asked for assistance in providing any, and all additional information or documentation regarding Resident #59. The investigation for this incident was again requested at this time. An investigation was presented at approximately 3:00 PM regarding Resident #59. The investigation was reviewed and documented that the resident was observed cutting her wrists with a disposable shaving razor. EMS was called and transported the resident to the emergency department. The summary documented that first aid was provided prior to the resident leaving the facility and staff remained with the resident until EMS arrived. The summary documented that an investigation was completed on [DATE] to include employee interviews and medical review. The root cause analysis in the summary documented it was determined that the cause of the resident's behavior was a reaction to the attending physician's decision to not use narcotics and that the resident has a history of engaging in attention seeking behavior. The actual investigation documented several witness statements from staff, including a statement from licensed practical nurse (LPN) #8. The statement by LPN #8 documented, Somewhere in 2017 during the last quarter of the year made a statement that she would rather die than not have her hydrocodone pain medicine. She only made it once and never repeated it. This was reported to the, then DON who instructed this nurse not to worry about it .[LPN #8]. A statement by CNA #2 documented, .realize something was wrong with [name of Resident #59] wrist while we were trying to put gloves on she was continuously using the shaving stick cutting on her wrist faster and faster .manage to take it away after putting her gloves on . [CNA #2]. It was documented within the investigation that razors were found in patients room that were not facility issued or acquired. The investigation did not determine where the razor(s) came from or how the resident obtained the razor. The investigation did not have a statement from the resident. The resident was a 15 cognitively, but was not interviewed regarding the event. The resident was not interviewed prior to leaving the facility for the emergency department and was not interviewed after readmission to the facility. At approximately 3:30 PM, the survey team met with the administrator, DON and corporate nurse. They were again made aware of concerns of actual harm of this resident. The facility staff were also made aware that the investigation was not complete and accurate. The facility staff were asked how the resident got the razor or where did she get it from. The facility staff did not provide information on where or how the resident obtained a razor. The facility staff were asked if the resident was interviewed and the staff did not provide a response. No statements were found for Resident #59. On [DATE] at 4:49 PM, the survey team again met with the corporate nurse, administrator and DON. No other information or documentation was presented for this resident regarding this incident or investigation. The corporate nurse stated that there were no other psych consults found for this resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 5:20 PM, the administrator stated that the MD (medical director) may have information regarding Resident #59. The administrator and MD met with the survey team at this time. The MD stated that the resident did not like getting medications other than narcotics and that the resident had an opioid addiction at one time due to chronic pain. The MD stated, We'd [the facility] been trying to deal with drug seeking behaviors. The administrator and MD was asked if the resident was referred to a pain clinic or to psych services. The administrator stated that the resident was not referred to a pain clinic, but stated that the resident was seen regularly by psych and that the facility had made multiple referrals for this resident, which she refused. The administrator and MD were made aware that only one psych consult observed in the resident's clinical record dated ,d+[DATE], and that no referrals were found in the resident's chart, nor any documentation found that the resident refused any type of referral. The MD was asked about the resident attempting suicide by cutting her wrist with a disposable razor. The MD stated, It was simply a suicidal gesture, that's all. The MD was asked again about interventions for this resident and/or outside services to assist this resident with the multitude of problematic depressive/behavioral/suicidal ideation symptoms. The MD stated, that he believed we did all we could do. The MD was asked, along with the administrator, where the resident got the razor or how the razor was obtained by the resident. The administrator, nor the MD made any comments regarding this. The MD again stated, We had plenty of referrals and she refused if you look in the record, you'll see the documentation. The MD was made aware that no documentation was found in the resident's clinical record to support those statements. The resident's discharge summary from the hospital dated [DATE] documented, .Admission Primary diagnosis: Status migrainosus, intractable and suicidal ideation .history notable for multiple sclerosis, chronic migraines, depression COPD, opioid use disorder and suicide attempt due to medication overdose who presented to the ED after attempted suicide .onset of a migraine 2 weeks ago .she reports she has not been sleeping for months. She says the pain was so bad that she decided to cut her wrist .she continues to endorse active suidical ideation .she attributed her suicidal ideation to her intractable severe migraines. Psychiatry evaluated the patient and felt her presentation was consistent with an adjustment disorder with mixed disturbance of emotions and conduct .she denied suicidal ideation when reevaluated by psychiatry on [DATE] .cleared for discharge back to her skilled nursing facility .ambulatory referral to [name of psychiatrist] or .may continue to follow with the psychiatrist's at the SNF. No further information and/or documentation was presented prior to the exit conference on [DATE] at 6:15 PM to evidence the facility staff provided supervision and interventions for the prevention of self harm for Resident #59, after the resident had been identified by facility staff as being at risk for self harm. THIS IS A COMPLAINT DEFICIENCY. 40027 Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation, the facility staff failed to ensure supervision for the prevention of accidents for one of 19 residents in the survey sample, Resident #29. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #29 was admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included sepsis, type 2 diabetes, hypertension, malnutrition, acute gastritis, stage IV pressure wound, multifactoria dementia, deafness requiring cochlear implant, hepatitis C, and chronic obstructive pulmonary disease (COPD). The most recent minimum data set (MDS) dated [DATE], a quarterly assessment, assessed Resident #29 as being severely cognitively impaired with a score of 03 out of 15 for daily decision making. The state agency received 2 facility reported incidents (FRI) regarding Resident #29 being found outside. The first FRI was dated [DATE] which resulted in Resident #29 being sent to the local emergency room . The second FRI was dated [DATE]. The state agency received a facility reported incident (FRI) on [DATE] that documented an injury of unknown origin. The report documented the following: [Resident #29] was found on ground, outside, beside wheelchair. Resident sent to hospital via 911. The follow-up investigation report was received by the state agency on [DATE]. The follow-up report documented the following: On [DATE], [Resident #29] was found by facility staff on ground, next to his wheelchair. [Resident #29] was assessed by nursing staff and found to be swollen in his left temporal area. No lacerations or contusions were evident. [Resident #29] was transported to a local hospital Emergency Department for evaluation and returned to the facility the same day .An investigation was completed on [DATE] to include employee interviews. After investigation, facility determined [Resident #29] injuries were consistent with a fall from a wheelchair. [Resident #29] does not show any signs and symptoms of psychosocial distress. The investigation report was signed by the facility administrator. On [DATE] the facility's investigation was reviewed. The investigation documented only one witness statement from the facility's maintenance director (OS #2). The witness statement documented the following: On [DATE], I walked out the patio door and found [Resident #29] laying on the ground by the drink machine. I then went and got the nurse, and brung them to him. The witness statement was signed by the OS #2 and the facility's administrator. On [DATE], Resident #29's clinical record was reviewed. An readmission assessment was completed on [DATE] at 17:30 p.m. and documented the following under the elopement risk evaluation: 1. Is resident cognitively impaired? Response: Yes 2. Is resident independently mobile (ambulatory or wheelchair)? Response: Yes 3. Does resident have poor decision making skills? Response: Yes 4. Has resident demonstrated exit-seeking behaviors? Response: Yes 5. Does resident wander oblivious to safety needs? Response: Yes 6. Does resident have a a history of elopement? If yes, # of times, if known ___ (left blank). Response: Yes 7. Does resident have the ability to exit the facility? Response: Yes (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The elopement risk evaluation documented the following: YES to questions 4, 5, or 6 automatically place the resident AT RISK . Based on potential risk factors above, resident is determined to be AT RISK for elopement. Response: Yes . If it is determined that the resident has eloped, implement care plan immediately to ensure resident's safety. Report all residents AT RISK to the Director of Clinical Services and on the 24-Hour Report. Resident #29's care plan which was in place at the time of the readmission [DATE] was reviewed and documented the following: Focus: [Resident #29] has inappropriate behaviors. AEB (as evidenced by) sexually inappropriate behavior, other behaviors include hitting, refusing care, yelling, attempt to elope. Date initiated [DATE]. Revision on [DATE]. Goals: [Resident #29] will not display inappropriate sexual behaviors towards staff through next review. Date initiated: [DATE]. Revision on [DATE]. Interventions: Wander Guard protocol. Date initiated [DATE]. Revision on [DATE]. There were no person centered interventions regarding elopement risk or supervision. The intervention for wander guard protocol was not initiated until [DATE], after the elopement risk assessment on [DATE] which documented Resident #29 as at risk for elopement, and after the resident was found outside with injury on [DATE]. A review of the emergency room visit on [DATE] documented the following: .Apparently EMS noted that his pupils [Resident #29] were not reacting, however they are reactive here. I did order the CT which shows no acute abnormality. His sister [name] is now here and states he is aback to his baseline. Therefore we will discharge him back to [name of facility] and she will sign the paperwork to put him back in hospice. She is comfortable with this plan. The emergency room visit was signed by the attending ER physician on [DATE] at 20:44 (8:45 p.m.). On [DATE] at 10:00 a.m., the maintenance director (OS #2) was interviewed about the FRI which took place on [DATE]. OS #2 stated he was going outside on the patio for his smoke break and observed Resident #29 laying on the ground near the soda machine. OS #2 stated there was no one else outside with Resident #29. OS #2 stated Resident #29 did not say how he fell , only said get me up. OS #2 stated he hollered up the hall to the nursing station for a nurse to come and assess Resident #29. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:30 a.m., the director of nursing (DON) was interviewed about the FRI which took place on [DATE]. The DON stated she was on vacation when the incident took place. The DON stated Resident #29 had always been allowed to go outside unsupervised as the facility had a discussion with his sister about letting him go outside because he enjoyed the sunny weather. The DON continued and stated Resident #29 was safe to be outside alone and he would let himself in/out of the patio door. The DON was interviewed regarding the re-admission assessment on [DATE] which assessed Resident #29 as an elopement risk. The DON stated Resident #29 was an elopement risk; however, at the time of the assessment he had not tried to elope. The DON was asked to review the care plan which was initiated on [DATE] with a focus area documenting Resident #29's behaviors that included attempted to elope. The DON stated the nurse who completed the readmission assessment on [DATE] was no longer employed at the facility and there should have been a care plan to address the elopement and supervision. The DON stated she did update the care plan to include the wander guard after the [DATE] incident when Resident #29 was found outside alone on the ground. The state agency received a FRI on [DATE] that documented the following incident type: Resident Elopement. The FRI documented the following: [Resident #29] was observed by staff outside of building while on facility property. [Resident #29] immediately assisted back inside by staff without injury or resistance. An assessment was completed by the charge nurse identifying no new signs or symptom of impairments or psychosocial distress The facility's follow-up investigation documented the following: .It was determined [Resident #29] was unsupervised on the enclosed porch area outside. This permitted [Resident #29] to access the front parking lot where he was observed and subsequently returned to the facility. The Director of Nursing immediately began a all staff education initiative on resident supervision when on the porch. Upon return to the floor, an assessment was completed on [Resident #29] by the Charge Nurse identifying no new signs or symptoms of impairments or psychosocial distress. As skin assessment was performed, no marks, bruising/scrapes noted. [Resident 29] did not complain of pain or discomfort. Neurological checks were found to be within normal limits. [Resident was placed on safety checks]. The investigative report was signed by the administrator. A review of the facility's investigation documented the following witness statements from two nurses who were on duty the night of the incident: Nurse #1: 2140 - this nurse administered medication to resident at nurses station. resident self propelled in w/c towards patio door 2141 - alarm at patio door activated, this nurse turned alarm off made visual contact with resident, this nurse advised res (resident) is allowed by facility to be on patio unsupervised 2145 - this nurse walked out front door to facility observed res sitting/scooting around at edge of parking lot. immediately requested assistance from staff. resident assisted in w/c, wheeled inside, assisted to bed, vs/neuro vs done.

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F 0740

Level of Harm - Actual harm

Residents Affected - Few

Ensure each resident must receive and the facility must provide necessary behavioral health care and services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 27353

Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation, the facility staff failed to provide necessary behavioral health care and services to maintain the highest practicable physical, mental and psycho-social well-being for one of 19 residents in the survey sample, Resident #59.

In May of 2018, Resident #59 was assessed by the facility as having thoughts of self harm and an immediate threat to herself. The facility failed to develop a plan of care for the prevention of self harm, and Resident #59 was not provided with behavioral health care and services after this assessment. Resident #59 subsequently cut her wrist with a disposable razor and was sent to the hospital for treatment, resulting in harm.

Findings include:

Resident #59 admitted to the facility on [DATE]. Diagnoses included, but were not limited to: anemia, thyroid disorder, osteoarthritis, MS (multiple sclerosis), anxiety disorder, depression, neuralgia, neuritis, chronic pain syndrome, intractable migraines, and opioid abuse.

An annual MDS (minimum data set) dated [DATE] documented the resident was a score of 15 for cognition, indicating the resident was cognitively intact for daily decision making skills. The resident was documented with a score of 23 [range ,d+[DATE]] for total severity of mood and was also assessed on this MDS as having potential for self harm. The resident was extensive assist with most ADLs (activities of daily living) with at least one person assist. The resident triggered for cognition, ADL function, urinary, mood, psychosocial, behavior, falls, nutrition, psychotropic drug use, and pain in the CAAS (care area assessment summary) section of this MDS.

A quarterly assessment dated [DATE] was reviewed and documented the resident's cognitive score of 15 (intact for daily decision making skills) and the resident's total mood score was 20, still a high score of depressed mood. Section: D03050. Safety Notification: was blank.

A significant change assessment dated [DATE] documented the resident with a cognitive score of 15 indicating the resident was intact for daily decision making skills. The total severity score for mood on this MDS was scored 16. The resident was also documented as having delusions and verbal behaviors toward others, with the presence of overall behavioral symptoms as worse. The resident was assessed as requiring limited assistance with at least one person assist for most ADLs (physical improvement from last MDS assessment).

A complaint investigation was completed on Resident #59 on [DATE] through [DATE]. An allegation within the complaint alleged that Resident #59 injured self ([DATE]) with a disposable razor that was not a facility issued item, 911 was called and the resident was taken to the hospital and then readmitted back to the facility on [DATE].

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2019
NAME OF PROVIDER OR SUPPLIER: Oakhurst Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 4238 James Madson Highway Fork Union, VA 23055	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Actual harm Residents Affected - Few	Resident #59's closed clinical records were reviewed. The resident's physician order sheet and interim plan of care dated [DATE] (original admission) was reviewed and documented, the resident as having .vitamin B 12 deficiency, opioid abuse, MS, migraines, GERD, anxiety, major depressive disorder, hypothyroidism, chronic pain syndrome, osteoporosis, neuralgia and neuritis. The treatment/care plan was to: adjust to nursing facility placement for long term care .regular diet .may participate in activity and general conditioning program as desired, may attend religious and social activities without limitations or precautions unless otherwise notes . The resident's POS (Physician order set) for [DATE] through [DATE] was reviewed and documented, .CPR . Regular mechanical soft diet .PAPER PLATES AND PLASTIC UTENSILS ONLY .bed against the wall . No orders for psychiatric services were found. A review of the clinical record revealed one psychiatric consult dated [DATE]. This consult documented, . seen evaluated .follow up depression last seen Nov. 2017 .today she looks much brighter than at previous visits . sleep: ok food: if you can call it food! .sitting up in bed .pleasant and cooperative with good eye contact .MOOD: 'This isn't any way to live' .looks brighter today .continue current meds. if depression symptoms persist, could increase .[wellbutrin 150 mg ER] to BID .can also consider trial of [effexor XR] in lieu of [zoloft] .discuss pt status with POA .signature of psychiatry/neurobehavioral services. The resident's physician's orders were reviewed from ,d+[DATE] through ,d+[DATE] and did not reveal either of the recommendations were implemented during this time. On [DATE] at approximately 9:00 AM, the administrator was asked for the investigation regarding Resident #59's self harm. On [DATE] at 9:45 AM, the SW was interviewed regarding Resident #59. The SW was asked about the MDS information for this resident. The SW stated that he completes sections C [cognitive patterns], D [Mood], and E [behavior] on the MDS. The SW was asked about Resident #59's annual MDS assessment dated May of 2018, specifically regarding the resident's high mood score along with documented concerns for self harm. The SW stated that if a resident answers the last question in that section with yes, then that triggers a response for the following self harm question which asked if there is a potential for resident self harm. The SW stated that is why that is marked yes, indicating knowledge of staff and/or the provider of potential for self harm regarding this resident. The SW was asked about the quarterly assessment in July (Mood Score 20) and the significant change assessment in August (Mood Score 16). The SW stated that the resident still had a high mood score, but did not voice hurting herself on those. The SW was asked if this type of information (self harm) should be care planned for the resident. The SW stated that it should be and thought it was for Resident #59. The SW was asked for the CAAS (care area assessment summary) worksheets for mood and behavior for the MDS assessments. The SW presented CAAS worksheet for the annual MDS assessment and for the significant change MDS assessment. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakhurst Health & Rehabilitation	4238 James Madson Highway Fork Union, VA 23055

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F 0740 Level of Harm - Actual harm Residents Affected - Few	The CAAS worksheet dated [DATE] documented, .psychosocial well being .The resident has a actual problem .often declines activities .depression .decline in ADL's .Mood or behavior problem that impacts interpersonal relationships .falls, pain .care planning for this problem, what is the overall objective: improvement .Describe impact of this problem .include complications and risk factors and the need for referral to other health professionals: Is a referral to another discipline warranted? No .Mood State: Resident has had thoughts that he/she would be better off dead, or thoughts of hurting him/herself as indicated by: Thoughts that you would be better off dead, or of hurting yourself in some way .yes .Analysis of Findings: has a actual problem with feeling hopeless .reported that at times she feels that she would be better off dead due to her illness .Relapse of an underlying mental health problem .Psychiatric disorder, anxiety, depression, manic depression .pain .mental health and health issues contribute to thoughts of not living. The resident is often observed throughout the day in bed in and out of sleep .Mood State- care planning for this problem, what is the overall objective: improvement Behavioral Symptoms .has a actual problem with rejecting ADL care .needs several prompts and encouragement from staff for bathing and dressing .Seriousness of the behavioral symptoms: Resident is immediate threat to self - IMMEDIATE INTERVENTION REQUIRED . Resident's behavior status, care rejection, or wandering has worsened since last assessment .At times the resident has thoughts of being better off dead. The resident has a dx [diagnosis] of MS which contributes to feelings of hopelessness, stressed that she gets sad when she thinks about being 'crippled up in the bed' . Care plan consideration Will behavioral symptoms- functional status be addressed in the care plan? Yes . Improvement .Referral to Other Disciplines: Is a referral to another discipline warranted? No . The CAAS worksheet dated [DATE] documented, .psychosocial well being .verbal behavioral symptoms . actual problem with verbal behavior when she is unable to get her way .curses and calls staff names .has thrown food tray on the floor and thrown objects Depression .Mood or behavior problem that impacts interpersonal relationships .overall objective: improvement .minimize risks .Describe impact of this problem . include complications and risk factors .Is a referral to another discipline warranted? No .Mood State: has actual problem with regulating her mood .depression and anxiety .stressed that the pain caused by her MS and inability to walk makes her sad .Delusions .antipsychotics .improvement, slow or minimize decline . minimize risks .Care plan consideration Will Mood State- functional status be addressed in the care plan? Yes .Improvement .Is a referral to another discipline warranted? No .Referral: No . (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	The resident's CCP (comprehensive care plan) was reviewed prior to self harm incident ([DATE]) and documented, .is dependent on staff for activities, cognitive stimulation, social interaction .engage in activities . explain the importance of social interaction, encourage participation .in room visits .music .provide a calm non rushed environment .reality orientation .report c/o [complaints of] pain, discomfort .or any other c/o that interferes with resident's ability to participate .to the nurse .needs assistance/escort to and from activity . impulsive behavior .history of throwing glass plates when she becomes upset .psychotropic med use . adaptive equipment .walker/wheelchair .anticipate and meet the residents needs .keep needed items .in reach .medication as ordered .[name of resident] needs a safe environment .Resident to received plastic silverware and Styrofoam plates/bowls for all meals .keep call bell in within easy reach .medication as per physician order .monitor and report restlessness, agitation, confusion .monitor and report to MD [medical doctor] s/sx [signs and symptoms] of depression. Obtain order for mental health consult if needed .monitor and report medication side effects and effectiveness every shift .ADL-Observe skin for redness, open areas, scratches, cuts, bruises and report changes to nurse .bathing: provide resident with a sponge bath when a shower can not be tolerated .provide the resident with assistance to bathe daily and as needed .psychoactive use .antidepressant .depression .antipsychotic .depression .antianxiety .anxiety/agitation . non drug interventions- monitor behavioral symptoms and side effects such as appetite changes, memory impairment . antidepressants: report .signs and symptoms of depression or problematic side effects to practitioner . antipsychotic- monitor behavioral symptoms . evaluate medication response and resident's response quarterly .if side effect present report to practitioner .medication as ordered .non drug interventions-see behavior care plan .educate patient .on consequences of poor behavior choices/non compliance .encourage group activities .encourage resident to express feelings .monitor for increase in behaviors or unsafe behaviors and report to physician as needed .impaired thought processes .monitor and report to MD any changes in cognitive function, specifically changes in decision making ability, memory, recall, and general awareness .distress of yelling out when she is not due for pain medications, emotional distress .throwing items and cursing staff and c/o chronic unrelieved pain .anticipate the resident's need for pain relief .assess coping strategies .attempt non pharmacological interventions .distraction .express feelings .monitor and report to nurse resident complaints of pain or requests for pain treatment .monitor and report to .nurse . mood/behavior changes, more irritable, restless, aggressive, squirmy, constant motion .psych consult as needed . No information was on the resident's CCP regarding any self harm, or statements of the resident stating, being better off dead', and there were no interventions to address these identified concerns. None of the information from the above MDS and/or CAAS Worksheets regarding this resident's risk for self harm was incorporated in any way into the resident's CCP. The progress and nursing notes were reviewed for this resident for 2018 and included the following: A progress note dated [DATE] documented, .continues to display inappropriate behaviors at times, she throws her food tray and other objects on the floor when she is unable to get her way, when upset .verbally abuses staff by cursing and calls them names based on skin color .prefers to lay in bed most of the day, struggles with staying safe .has had a few falls .signature of [social worker]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Oakhurst Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4238 James Madson Highway Fork Union, VA 23055	

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F 0740 Level of Harm - Actual harm Residents Affected - Few	A progress note dated [DATE] documented, .threw food tray full of food onto floor, when given medications she throw back [sic] at nurse .attempted to pinch/punch and bite nurse and CNA that was assisting back into her w/c. [name of resident] propels to the nursing station and made allegations of sexual assault .[name of resident] started chasing female nurse in w/c which led to the sheriff department being called .investigate allegations of sexual assault .[name of resident] she struggle with [sic] recalling the behavior she displayed and stated she never said anybody sexually assaulted her .new med order for Ativan 1 mg will continue to monitor .SW A progress note dated [DATE] documented, Significant change .alert and oriented with some forgetfulness/confusion is able to recognize some staff by name, able to make needs known all needs met by nursing .often observed in bedroom by choice, this is often due to depression .Significant change due to ongoing behavior issues .SW A nursing note dated [DATE] documented, resident came out of room and demanded Tylenol. she then made rude statements and became agitated. Redirecting her didn't help .made paranoid statements about the Tylenol .went back to room and then came back out and accused us [staff] of removing pictures from her room . A nursing note dated [DATE] (no time stamp) documented, At approximately 10 AM this writer was alerted to the front lobby where I was met by a police officer, patient had called 911 stated that she was ringing her call light since 8:15 with no answer. Escort police officer X 3 to patients room patient stated that she had migraine [sic] and nurse would not provide me [sic] with medications for my migraine this nurse offered PRN [as needed] Zomig - schedule excedrine patient refused stated, 'your not a nurse your uneducated go back to school, I'm gonna sue the doctor for malpractice police officer talked with patient to .while offered to send patient to ER [emergency room] patient refused MD notified no new medication order per MD narcotic not appropriate for migraines - patient had requested 'strong' pain medication patient refused am medications - prior to police arrival patient had thrown tray across room when asked why she stated 'I can't eat that' per CNA [certified nursing assistant] statement she had placed breakfast tray in at approximately 8:00 AM and had been in room X 2 between then and 9:30 and nurse (LPN) stated that she had also been in patients room between those times patient aware of no new medications patient told this RN to get out of my room again stated that she was going to sue the MD no further behaviors this shift . A nursing note dated [DATE] at 3:45 PM documented staff reported resident requested to see nurse this nurse responded immediately to find resident cutting L [left] wrist inner with shaving razor this nurse repeatedly asked resident to stop she stated 'no I want morphine' this nurse removed razor from resident and applied towel with pressure to L inner wrist resident attempted to kick this writer yelling 'I have to wait 20 more minutes before I can have my medicine and I don't want to wait staff stayed 1:1 with resident while this nurse called 911 for transport to ED [emergency department], ADON [assistant director of nursing], notified immediately of incident, MD notified . (continued on next page)

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	495230	A. Building B. Wing	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakhurst Health & Rehabilitation	4238 James Madson Highway Fork Union, VA 23055

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at approximately 11:30 AM, the administrator, DON and corporate nurse were made aware of serious concerns with Resident #59 in a meeting with the survey team. The facility staff were made aware of the lack of interventions and/or services provided to prevent accidents/self harm for this resident. The facility staff were made aware that this resident had been identified by facility staff as having a high mood score for depression and as being a risk for self harm in May of 2018, with no interventions developed or implemented for the prevention of accidents/self harm for this resident. The staff were asked for assistance in providing any, and all additional information or documentation regarding Resident #59. The investigation for this incident was again requested at this time. An investigation was presented at approximately 3:00 PM regarding Resident #59. The investigation was reviewed and documented that the resident was observed cutting her wrists with a disposable shaving razor. EMS was called and transported the resident to the emergency department. The summary documented that first aid was provided prior to the resident leaving the facility and staff remained with the resident until EMS arrived. The summary documented that an investigation was completed on [DATE] to include employee interviews and medical review. The root cause analysis in the summary documented it was determined that the cause of the resident's behavior was a reaction to the attending physician's decision to not use narcotics and that the resident has a history of engaging in attention seeking behavior. The actual investigation documented several witness statements from staff, including a statement from licensed practical nurse (LPN) #8. The statement by LPN #8 documented, Somewhere in 2017 during the last quarter of the year made a statement that she would rather die than not have her hydrocodone pain medicine. She only made it once and never repeated it. This was reported to the, then DON who instructed this nurse not to worry about it .[LPN #8]. A statement by CNA #2 documented, .realize something was wrong with [name of Resident #59] wrist while we were trying to put gloves on she was continuously using the shaving stick cutting on her wrist faster and faster .manage to take it away after putting her gloves on . [CNA #2]. It was documented within the investigation that razors were found in patients room that were not facility issued or acquired. The investigation did not determine where the razor(s) came from or how the resident obtained the razor. The investigation did not have a statement from the resident. The resident was a 15 cognitively, but was not interviewed regarding the event. The resident was not interviewed prior to leaving the facility for the emergency department and was not interviewed after readmission to the facility. At approximately 3:30 PM, the survey team met with the administrator, DON and corporate nurse. They were again made aware of concerns of actual harm of this resident. The facility staff were also made aware that the investigation was not complete and accurate. The facility staff were asked how the resident got the razor or where did she get it from. The facility staff did not provide information on where or how the resident obtained a razor. The facility staff were asked if the resident was interviewed and the staff did not provide a response. No statements were found for Resident #59. On [DATE] at 4:49 PM, the survey team again met with the corporate nurse, administrator and DON. No other information or documentation was presented for this resident regarding this incident or investigation. The corporate nurse stated that there were no other psych consults found for this resident. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 5:20 PM, the administrator stated that the MD (medical director) may have information regarding Resident #59. The administrator and MD met with the survey team at this time. The MD stated that the resident did not like getting medications other than narcotics and that the resident had an opioid addiction at one time due to chronic pain. The MD stated, We'd [the facility] been trying to deal with drug seeking behaviors. The administrator and MD was asked if the resident was referred to a pain clinic or to psych services. The administrator stated that the resident was not referred to a pain clinic, but stated that the resident was seen regularly by psych and that the facility had made multiple referrals for this resident, which she refused. The administrator and MD were made aware that only one psych consult observed in the resident's clinical record dated ,d+[DATE], and that no referrals were found in the resident's chart, nor any documentation found that the resident refused any type of referral. The MD was asked about the resident attempting suicide by cutting her wrist with a disposable razor. The MD stated, It was simply a suicidal gesture, that's all. The MD was asked again about interventions for this resident and/or outside services to assist this resident with the multitude of problematic depressive/behavioral/suicidal ideation symptoms. The MD stated, that he believed we did all we could do. The MD was asked, along with the administrator, where the resident got the razor or how the razor was obtained by the resident. The administrator, nor the MD made any comments regarding this. The MD again stated, We had plenty of referrals and she refused if you look in the record, you'll see the documentation. The MD was made aware that no documentation was found in the resident's clinical record to support those statements. The resident's discharge summary from the hospital dated [DATE] documented, .Admission Primary diagnosis: Status migrainosus, intractable and suicidal ideation .history notable for multiple sclerosis, chronic migraines, depression COPD, opioid use disorder and suicide attempt due to medication overdose who presented to the ED after attempted suicide .onset of a migraine 2 weeks ago .she reports she has not been sleeping for months. She says the pain was so bad that she decided to cut her wrist .she continues to endorse active suidical ideation .she attributed her suicidal ideation to her intractable severe migraines. Psychiatry evaluated the patient and felt her presentation was consistent with an adjustment disorder with mixed disturbance of emotions and conduct .she denied suicidal ideation when reevaluated by psychiatry on [DATE] .cleared for discharge back to her skilled nursing facility .ambulatory referral to [name of psychiatrist] or .may continue to follow with the psychiatrist's at the SNF. No further information and/or documentation was presented prior to the exit conference on [DATE] at 6:15 PM to evidence the facility staff provided supervision and interventions for the prevention of self harm for Resident #59, after the resident had been identified by facility staff as being at risk for self harm. THIS IS A COMPLAINT DEFICIENCY.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 21875 Based on observation, staff interview and clinical record review, the facility staff failed to ensure a medication error rate of less than 5 percent. Medication pass observations revealed three errors out of 39 opportunities resulting in a 7.6 % error rate. The findings include: 1. A medication pass observation was conducted on 3/20/19 at 8:00 a.m. with registered nurse (RN) #1 administering medications to Resident #18. During this observation, RN #1 administered the medication Carbamazepine 200 mg (milligrams) to Resident #18. Resident #18's clinical record documented a physician's order dated 5/31/17 for Carbamazepine 400 mg to be administered each day at 8:00 a.m. for treatment of a seizure disorder. On 3/20/19 at 8:50 a.m., RN #1 was interviewed about the Carbamazepine administered to Resident #18. RN #1 reviewed the physician's order and stated the resident had two orders for the Carbamazepine with 400 mg to be given at 8:00 a.m. and 600 mg to be given at 8:00 p.m. RN #1 at this time reviewed Resident #18's medication supply cards in the cart. Resident #18 had a card of Carbamazepine 400 mg and another card supplied with Carbamazepine of 200 mg. These findings were reviewed with the administrator and director of nursing during a meeting on 3/20/19 at 4:50 p.m. 27353 2. During a medication pass and pour observation on 03/20/19 at 8:16 AM, LPN (Licensed Practical Nurse) #1 prepared medications for Resident #43 which included one EC (enteric coated) 81 mg (milligram) ASA (aspirin) tablet. LPN #1 then removed two bottles of eye drop medications from the medication cart, including Prednisone 1%. LPN #1 took the medications into the room and informed the resident that she would first administer one of the eye drops, then administer the pills and then administer the other eye drops. The LPN took the first bottle of eye drops and administered one drop into each eye. The resident then took the pills, including the ASA 81 mg EC tablet and then the LPN administered the second bottle of eye drops, Prednisone 1%, administering one drop into each eye. LPN #1 washed her hands and then exited the room. On 03/20/19 at 8:33 AM, a medication reconciliation was completed. Resident #43's current physician's orders were reviewed and revealed an order for: Aspirin 81 mg chewable tablet and Prednisone 1% eye drop solution- one drop in the right eye. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/20/19 at 9:00 AM, LPN #1 was interviewed regarding Resident #43. LPN #1 was made aware that she administered the resident an enteric coated Aspirin and the resident's order was for an Aspirin 81 mg chewable tablet. LPN #1 looked at the physician's order and then went to the MAR (medication demonstration record) and stated, Yes, I did and further stated that almost all of the residents on her hall who receive Aspirin, receive the Aspirin EC and only a couple get the chewable. LPN #1 was then made aware of administering the resident Prednisone 1% eye drops in both eyes, when the physician's order was for one drop in the right eye only. LPN #1 stated, I did, I don't even have to look, I know I'm only suppose to give one, that was all me, I was nervous. The administrator and DON (director of nursing) were made aware in a meeting with the survey team on 03/20/19. A policy on medication administration was requested at this time. A policy on General Dose Preparation and Medication Distraction was presented and reviewed. The policy documented, .facility staff should verify that the medication name and dose are correct .verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route .at the correct time, for the correct resident confirm that the MAR reflects the most recent medication order . No further information and/or documentation was presented prior to the exit conference on 03/21/19 at 6:15 PM.

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F 0800

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 21875

Based on observation, staff interview and clinical record review, the facility staff failed to ensure an accurate meal ticket for one of 19 residents in the survey sample. In addition, the facility failed to ensure a system for printing meal tickets in the facility that accurately reflected physician ordered therapeutic diets, food allergies and resident preferences. Resident #23, served a puree diet, had a meal ticket for a mechanical soft diet. The ticket documented the resident was served ground pork when puree turkey was actually served. The ticket indicated ground pork was served when ticket instructions stated No Pork. The facility had an unresolved issue with inaccurate meal tickets since April 2018.

The findings include:

1. Resident #23 was admitted to the facility on [DATE] with a re-admission on 3/17/19. Diagnoses for Resident #23 included dementia, dysphagia, high blood pressure and history of hip fracture. The minimum data set (MDS) dated [DATE] assessed Resident #23 with severely impaired cognitive skills.

On 3/19/19 at 12:30 p.m., Resident #23 was observed eating lunch in her room. The resident's food items included a puree white meat, vegetable, rice mixture and bread. Resident #23's meal ticket documented the resident's diet was regular - mechanical soft with instructions printed in bold, NO PORK AND NO SHRIMP. The food items listed on the ticket included ground roasted pork, cheesy rice, sliced cauliflower, ground pineapple tidbits, one square cornbread with 8 ounces of milk. There was no milk served on the lunch meal tray as listed on the ticket.

Resident #23's clinical record documented a nutrition assessment dated [DATE] for no pork or shellfish due to religious preferences. The record documented a physician's order dated 3/17/19 for a regular dysphagia puree diet.

On 3/19/19 at 12:53 p.m., the licensed practical nurse (LPN #1) caring for Resident #23 was interviewed about the meal ticket for mechanical soft and no pork. LPN #1 stated the resident's preference for no pork or shrimp was due to religious reasons. LPN #1 stated she did not know why the ticket listed pork was served when the ticket stated no pork. LPN #1 stated the resident was ordered a puree diet since her return from the hospital on 3/17/19.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakhurst Health & Rehabilitation	4238 James Madson Highway Fork Union, VA 23055

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/19 at 3:07 p.m., the dietary manager was interviewed about Resident #23's meal ticket. The dietary manager stated the meal ticket was inaccurate. The dietary manager stated the posted menu items printed on meal tickets even when preferences or instructions were in conflict with the menu items. The dietary manager stated, I don't know how to take it (menu items) off the ticket. The dietary manager stated Resident #23 was actually served puree turkey for lunch and not ground pork as listed on the ticket. The dietary manager stated, My staff just know to not give her [Resident #23] mechanical soft. The dietary manager stated the meal ticket on Resident #23's tray was not accurate and was printed before the resident went to the hospital. The dietary manager stated she printed tickets ahead and if changes in diets occurred, she was supposed to print a new ticket. The dietary manager stated she did not know why the old ticket was not removed and a new ticket printed after the resident's re-admission on 3/17/19. The dietary manager stated she had ongoing problems with printing accurate meal tickets. The dietary manager stated she had reported the problem to corporate and they did not know how to prevent the posted menu items from automatically printing on tickets even when residents had orders, allergies or preferences that required other food items. On 3/21/19 at 8:07 a.m., the dietary manager was interviewed again about the inaccurate meal tickets. The dietary manager stated she had experienced problems with printing accurate meal tickets since April 2018 when she started working at the facility. The dietary manager stated she entered therapeutic diets, allergies and dislikes and they showed on the computer but did not always show and/or print on the actual meal ticket. The dietary manager stated she verbally communicated changes/preferences to the tray line staff but knew the tickets did not always match the orders and/or preferences. The dietary manager presented another example of an inaccurate meal ticket for a current resident. The meal ticket for lunch (3/22/19) documented NO FISH .DISLIKES RICE .FISH .HAM then listed the food items to be served as baked stuffed fish fillet and rice pilaf. This meal ticket for dinner (3/22/19) listed sliced baked ham as the entree. The dietary manager stated again she did not know how to make the tickets print accurately. These findings were reviewed with the administrator and director of nursing during a meeting on 3/21/19 at 4:50 p.m.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for one of 19 residents in the survey sample. Resident 109's closed clinical record did not include records of treatments/dressing changes provided for wound care and the resident's bathing records were incomplete. The findings include: Resident #109 was admitted to the facility on [DATE] and was discharged to the hospital on 3/28/18. Diagnoses for Resident #109 included hip fracture, high blood pressure, peripheral vascular disease and diabetes. The minimum data set (MDS) dated [DATE] assessed Resident #109 with moderately impaired cognitive skills. a) Resident #109's closed clinical record documented the resident was admitted to the facility with a surgical wound on her left hip, a pressure ulcer to the sacrum and chronic wounds on toes of her left foot. The record documented a physician's order dated 3/10/18 for a Hydrogel dressing to the web of her left toes to be changed daily, barrier cream to pressure ulcers and clean, dry dressing on the left hip surgical incision. A physician's order dated 3/12/19 documented treatment orders for the pressure ulcers to include Santyl ointment to wound right of the sacrum every day and barrier cream each shift to wound left of sacrum. Resident #109's clinical record documented no treatment records for the dressing changes and topical medications to the pressure ulcers as ordered. On 3/21/19 at 11:25 a.m., the director of nursing (DON) was interviewed about any treatment records for Resident #109. After reviewing the closed clinical record, the DON stated she did not find the treatment record for Resident #109. The DON stated she had no idea what happened to the records. The DON stated she followed the resident's wound but did not know what happened to the record documenting the dressing changes/treatments. b) Resident #109's bathing records were requested in response to a complaint investigation. The DON presented a copy of bath records by shift during Resident #109's stay. There were no entries on 33 out of 54 shifts listed on the report from 3/11/18 through 3/28/18. On 3/21/19 at 3:45 p.m., the DON was interviewed about the missing bath records for Resident #109. The DON stated the aides were expected to enter activities of daily living information including bathing data into their tracking system at the end of each shift. The DON stated their tracking system had codes for entering showers, bed baths and partial baths for residents. The DON stated the bathing records for Resident #109 were incomplete as not all shifts entered information as required. These findings were reviewed with the administrator and DON during a meeting on 3/21/19 at 4:50 p.m.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 21875

Based on observation, staff interview and facility document review, the facility staff failed to follow infection control practices regarding hand hygiene during housekeeping; failed to implement infection control protocols for the prevention of Legionella and other water borne pathogens; and failed to follow infection control protocols during medication administration. A housekeeping staff member failed to perform hand hygiene after glove removal between cleaning of resident rooms and offices. The facility had no evidence of implementing maintenance and service items required in their water management program for the prevention of Legionella and other water borne pathogens. During a medication pass observation, a nurse dropped a medication on the top of the cart and then administered the medication to a resident.

The findings include:

1. On 3/19/19 at 11:15 a.m., a housekeeping staff member was observed with gloves on, sweeping the floor in room [ROOM NUMBER]. The housekeeper went into the resident's bathroom, flushed the toilet and emptied the trash from the room. The housekeeper handled the keys on her cart prior to removing her gloves. Without performing any hand hygiene, the housekeeper proceeded to the MDS office, put on new gloves and emptied the trash can from the office. The housekeeper changed her gloves and then went into room [ROOM NUMBER]. The housekeeper swept the floor and emptied trash cans in this room. The housekeeper changed her gloves and then went into room [ROOM NUMBER] and cleaned/swept the room. The housekeeper performed no hand hygiene after any glove removal.

On 3/21/19 at 8:53 a.m., a housekeeper was interviewed about their protocol for hand hygiene when cleaning rooms. The housekeeper stated gloves were to be on before entering resident rooms. The housekeeper stated after cleaning and emptying trash, she removed and discarded gloves before leaving the room. The housekeeper stated she had been instructed to wash hands or use hand sanitizer before going to the next room.

On 3/21/19 at 9:17 a.m., the housekeeping director was interviewed. The housekeeping director stated that housekeepers were expected to perform hand hygiene after glove removal and before leaving rooms during cleaning. The housekeeping director stated employees were expected to wash hands or use hand sanitizer and all of the housekeeping staff had training about hand hygiene.

The facility's policy titled General Hospitality Services Policies (11/30/2014) documented the policy objective was to provide clean, contamination-free surroundings for residents, visitors, and personnel. A clean environment is essential in preventing transmission of infection in the facility .Environmental Services will adhere to Standard precautions and Transmission-based Precautions as indicated .Gloves, i.e., utility gloves, will be worn . The facility's policy titled Personal Protective Equipment - Using Gloves (9/1/17) documented gloves were used to prevent the spread of infection and to protect hands from potentially infectious material and documented, Wash hands after removing gloves (Note: Gloves do not replace handwashing.) .

These findings were reviewed with the administrator and director of nursing during a meeting on 3/21/19 at 4:50 p.m.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The facility's protocols for the prevention of Legionella and other water borne pathogens were reviewed on 3/21/19. The facility's policy titled Water Management Program (8/1/17) documented, This center will provide a source of domestic water supply, as safe as possible, to all residents, staff, and visitors .will strive to eliminate the source of, or distribution of, unacceptable levels of preventable contamination (including but not limited to legionella, cryptosporidium, arsenic) within its water and HVAC systems. The policy listed the following preventive maintenance items as interventions for prevention of Legionella and other water borne pathogens: Daily water temperature checks; preventive maintenance of all hot water mixing valves; operational checks of water circulation pumps; cleaning of A/C drain lines and condensation pans; maintenance of all roof drains and any pitch pans; daily disinfection of installed drinking fountains; and routine maintenance of in-line water filters, water softeners including ice machines. The policy required the establishment of safety control limits such as temperatures and disinfectant levels with ongoing monitoring compared to established control limits with action taken for results not meeting established guidelines. On 3/21/19 at 11:15 a.m., the facility's maintenance director was interviewed regarding evidence of maintenance and testing for prevention of Legionella as listed in their policy. The maintenance director stated, We don't test for that [Legionella]. The maintenance director stated he had not set up anything different from what he had been doing prior to the Legionella requirements. The maintenance director stated he checked daily water temperatures and there was a diagram showing the water flow throughout the facility but he had no further testing results or preventive maintenance records regarding Legionella prevention. On 3/21/19 at 2:50 p.m., evidence of the preventive maintenance and testing required in their Water Management Program was requested from the administrator. On 3/21/19 at 4:00 p.m., the administrator presented daily water temperature checks and stated he had no other documented evidence of Legionella prevention. The administrator stated, The other items we do but we don't have documentation. Other than the daily water temperature checks, no other evidence was presented indicating implementation of the facility's Water Management Program for prevention of Legionella. These findings were reviewed with the administrator and director of nursing during a meeting on 3/21/19 at 4:50 p.m. 27353 3. During a medication pass and pour observation on 03/20/19 at 8:00 AM, LPN (Licensed Practical Nurse) #1 prepared medications for Resident #24. LPN #1 prepared the medications for this resident, which included one Spiriva 18 mcg (microgram) capsule for inhalation. LPN #1 removed the box from the medication cart, removed one package (containing one capsule), applied gloves and opened up the individual package. LPN #1 dropped the capsule onto a piece of paper that was laying on top of the medication cart. LPN #1 picked up the capsule and again, dropped the capsule on top of the piece of paper laying on the medication cart. LPN #1 picked up the capsule, inserted it into the dispensing inhaler and administered the medication to the resident. LPN #1 was made aware of dropping the capsule (Spiriva) on the med cart, landing on top of a piece of paper twice during medication preparation. LPN #1 stated, Yes, I did. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The administrator and DON (director of nursing) were made aware in a meeting with the survey team on 03/20/19. A policy on infection control practices for handling medications during medication administration was requested at this time. A policy on General Dose Preparation and Medication Distraction was presented and reviewed. The policy documented, .facility staff should not touch the medication when opening a bottle or unit dose package .if a medication which is in a protective container is dropped, facility staff should discard it .if a medication which is not in a protective container is dropped .staff should discard it No further information and/or documentation was presented prior to the exit conference on 03/21/19.