F 000 INITIAL COMMENTS

An unannounced Medicare/Medicaid standard survey was conducted 8/16/16 through 8/18/16. Corrections are required for compliance with the following Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 130 certified bed facility was 123 at the time of the survey. The survey sample consisted of 21 current resident reviews (Residents # 1 through # 21) and four closed record reviews (Residents #22 through #25).

483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES

The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual’s option, formulate an advance directive. This includes a written description of the facility’s policies to implement advance directives and applicable State law.

This REQUIREMENT is not met as evidenced

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

Bexley S. Davis MPA

TITLE

Administrator 9-9-2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excuse 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.

RECEIVED SEP 12 2016 VDH/OLC
3. Upon admission the Nursing Administrative Review Team, during Standards of Care (S.O.C) review, will check the medical record for any DDNR form. If present, the team will review form and verify resident’s wishes regarding code status and ensure a physician’s order is present and consistent with wishes. During care plan conferences the code status will be reviewed with the resident/RP by the MDS Coordinator or Social Service Representative to verify current wishes regarding code status, and verify correct physician order.

4. During the care plan process the MDS Coordinator or designee will audit the resident’s medical record and determine if a DDNR is present. If found they will ensure that the corresponding physician’s order is present and reflects resident’s code status wishes. This audit will be done by the MDS Coordinator, SS representative, or designee for 100% of residents x 3 months. Results of audits will be presented to the Quarterly Quality Assurance Committee Meeting.

5. Corrective Action will be completed on October 1, 2016.
F 155 Continuation From page 2

Not Resuscitate) form that documented, "I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain." The DNR form was dated June 19, 2015 and was signed by Resident #3 and the physician.

Further review of Resident #3's clinical record revealed an "Admission Record" that documented, "Code Status: DNR (Do Not Resuscitate)."

Resident #3's most recent signed physician's order summary dated 08/01/16 documented an order for a full code. Further review of the resident's clinical record failed to reveal documentation that the physician was made aware that Resident #3 had signed the DNR. There was no documentation evidencing a discussion had taken place to clarify whether Resident #3 should have had an order for DNR or if the resident was to remain a full code.

Resident #3's comprehensive care plan initiated on 07/07/15 documented, "(Resident #3)/Surrogate has exercised the right to self-determination. The resident/surrogate has decided after informed decision making to be 'Do Not Resuscitate Virginia Department of Health'" and order from the medical physician, DNR code...
F 155 Continued From page 3 status."

On 8/17/16 at 12:00 p.m. an interview was conducted with LPN (licensed practical nurse) #1, unit manager. When asked how she would determine a resident's code status, LPN #1 stated, "We have a list in the nurse's office and it is on the physician order sheet, and the face sheet. If a resident coded I would refer to which ever one was closest at the time." After reviewing Resident #3's face sheet, DDNR form, the physician's order sheet and care plan, LPN #1 stated, "The physician's order sheet contradicts the face sheet, DDNR form and the care plan."

When asked what should have been done, LPN #1 stated, "Call the responsible party and verify the code status, notify the physician and make changes as directed by the physician."

On 8/17/16 at 1:00 p.m. an interview was conducted with LPN #5. When asked how she would determine a resident's code status LPN #5 stated, "It's on the face sheet and if the resident is a DNR there is a DDNR. After reviewing Resident #3's face sheet, DDNR form, the physician's order sheet and care plan, LPN #5 stated, "The physician's order sheet contradicts the face sheet, DDNR form and the care plan."

When asked what should have been done, LPN #5 stated, "Notify the physician and get verification of the code status and notify the responsible party."

On 8/17/16 at 5:20 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above findings.

On 8/18/16 the facility provided this surveyor with
F 155
Continued From page 4

a "Physician's Telephone Order" for Resident # 3 dated 8/17/16. The physician's order documented, "Clarification order - Resident is a DNR."

No further information was presented prior to exit.

References:
(1) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

(2) Not enough thyroid hormone to meet your body's needs. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html.

(3) A blood disorder. This information was obtained from the website: https://medlineplus.gov/blooddisorders.html.

F 157
483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse effects.

F 157
1. Nursing failed to notify the physician, per physician's order, for resident #7 and resident #4. Physician has currently been notified of resident #7's O2 sats for 7/7 and 7/8 and resident #4's response to Tylenol order during period of time between 7/16 and 7/18.

O2 sats obtained on resident #7 for 7/7 and 7/8 revealed a range between 94-96% on room air. The Tylenol order obtained for resident #4 was administered on 7/16 with effective results documented. Pain assessment done on resident #4 indicates no current pain.
**NAME OF PROVIDER OR SUPPLIER**

**BROOKSIDE REHAB & NURSING CENTER**

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<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<td>F 157</td>
<td>Continued From page 5 consequences, or to commence a new form of treatment; or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</td>
<td>F 157</td>
<td>2. A 100% audit of all physician orders received from 8/1/ will be completed by the DON, ADON, UMs, or designee. This audit will identify any order for MD notification to ensure notification was completed as ordered, and documented.</td>
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<td>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</td>
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<td>3. All new physician's orders written will be reviewed by the Nursing Review team, during the SOC review meeting. Any order for physician notification will be documented on the lab tracking tool and followed up by the Unit Manager or designee to ensure notification occurs. The Weekend Supervisor or designee will implement review of all orders received during weekend hours, document MD notification orders on the lab tracking tool, and follow up on any notifications ordered during the weekend hours.</td>
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<td>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</td>
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<td>4. A 10% audit of all MD ordered notifications, as identified on the lab tracking tool will be done by the DON, ADON, UMs, or designee monthly times three months. Results of audits will be presented at the Quarterly QA Meeting.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify the physician regarding outcomes of physician ordered interventions for two of 25 residents in the survey sample, Resident #7's and 4.</td>
<td></td>
<td>5. Corrective action will be completed October 1, 2016.</td>
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<td>1. The facility staff failed to notify the physician on 7/8/16 of Resident #7's oxygen saturations, recorded every four hours as requested in a physician's order written on 7/7/16.</td>
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<td>2. The facility staff failed to notify Resident #4's physician 48 hours after Tylenol was initiated on 7/16/16 per the physician's order.</td>
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<td>The findings include:</td>
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F 157 Continued From page 6

1. The facility staff failed to notify the physician on 7/8/16 of Resident #7's oxygen saturations recorded every four hours as requested in a physician's order written on 7/7/16.

Resident #7, a 70 year old female, was admitted to the facility on 5/3/12, with a readmission on 1/19/16, with diagnoses that included, but were not limited to: metabolic encephalopathy [1] (a neurological disorder caused by systemic illness, such as diabetes, liver disease, renal failure and heart failure), hyperkalemia (elevated potassium levels in blood), malignant neoplasm of the sigmoid colon (cancer of part of the colon that leads to the rectum), vascular dementia and schizophrenia.

Resident #7's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 6/5/16. Resident #7 was coded on the Brief Interview of Mental Status as having a score of 15 out of a possible 15, indicating she is cognitively intact.

A review of Resident #7's clinical record revealed, in part, a physician order dated 7/7/16, signed by the physician on 7/9/16, that documented, in part, the following: "O2 (oxygen) at 2 (two) liters via nasal cannula. (Check mark) O2 sats (saturation) Q (every) 4 (four) hrs (hours). Report to (name of doctor) in AM (morning) - 7/8/16."

Further review of Resident #7's clinical record did not reveal any evidence that the physician had been notified of the O2 sats as requested in the order dated 7/7/16.

On 8/17/16 at 1:10 p.m. an interview was conducted with ASM (administrative staff...
F 157  Continued From page 7

member) #2, the director of nursing. ASM #2 was asked what a nurse should document in the nurses' notes, ASM #2 stated that the nurses are responsible for notes regarding any updates and/or changes to the residents' condition. ASM #2 further stated that the unit manager had been working with the nursing staff on documentation skills but could not state when this had started or if there had been any improvement.

On 8/17/16 at 5:20 p.m. an end of day meeting was conducted with ASM #1, the administrator and ASM #2, the director of nursing. The administrative staff were made aware of the above findings. ASM #1 and ASM #2 were asked to provide evidence that the physician had been notified of the O2 sats obtained on Resident #7 between 7/7/16 at 4:00 p.m. and 7/8/16 at 8:00 a.m. A policy regarding notifications to the physician was requested at this time.

An interview was conducted on 8/18/16 at 11:50 a.m. with LPN (licensed practical nurse) #1, the unit manager. LPN #1 was asked to review the physician order dated 7/7/16 and to indicate where the notification to the physician was documented regarding the O2 sats that were obtained between 7/7/16 and 7/8/16. LPN #1 stated that the notification would be in the nurses' notes; LPN #1 reviewed the nurses' notes and stated, "The doctor was not notified per the nurses' notes, there is no documentation."

A review of the facility policy titled "Notification of Physicians for Clinical Problems" did not reveal any documentation regarding notifying the physician as ordered.

No further evidence was provided prior to the end
**Brookside Rehab & Nursing Center**

**Name of Provider or Supplier:**
Brookside Rehab & Nursing Center

**Address:**
814 Hastings Lane
Warrenton, VA 20186

**ID Prefix TAG:**

<table>
<thead>
<tr>
<th>ID Prefix TAG</th>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
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| F 157         | Continued from page 8 of the survey process. 1. This information was obtained from the following website: http://www.ncbi.nlm.nih.gov/books/NBK20383/ 2. The facility staff failed to notify Resident #4's physician 48 hours after Tylenol (used to relieve mild to moderate pain) (1) was initiated on 7/16/16 per the physician's order. Resident #4 was admitted to the facility on 9/27/11. Resident #4's diagnoses included but were not limited to: Dementia (2), Osteoarthritis (3) and Gout (4). Resident #4's most recent MDS (Minimum Data Set), an annual assessment with an ARD (Assessment Reference Date) of 7/3/16, coded the resident's cognition as severely impaired. Section J documented Resident #4 had not voiced any complaints of pain during the five day look back period. Review of Resident #4's clinical record revealed a physician's order dated 7/16/16 that documented, "Tylenol 650 mg (milligrams) po (by mouth) q (every) 4 (hours) PRN (as needed) for discomfort x (times) 48 (hours) then notify md (medical doctor)." Resident #4's July 2016 MAR (Medication Administration Record) revealed the resident was administered Tylenol 650 mg on 7/16/16 at 2:30 P.M. for a complaint of "I'm sick." Further review of Resident #4's clinical record (including the MAR and nurses' notes) failed to reveal the resident's physician was contacted after the 48 hour period per the physician's order. Resident #4's comprehensive care plan revised on 7/12/15 documented, "The resident has...**
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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**NAME OF PROVIDER OR SUPPLIER**

**BROOKSIDE REHAB & NURSING CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

614 HASTINGS LANE
WARRENTON, VA 20186

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<td>F 157</td>
<td>Continued From page 9 Arthritis/ She is at risk for pain...Interventions: Monitor/document/report to MD (medical doctor) PRN s/sx (signs and symptoms) or complications related to arthritis: Joint pain, Joint stiffness, usually worse on wakening, Swelling, Decline in mobility, Decline in self-care ability, Contracture formation/joint shape changes, Crepitus (creaking or clicking with joint movement), pain after exercise or weight bearing...&quot;</td>
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On 8/17/16 at 7:35 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked to read the above physician's order. LPN #4 stated the order documented, "Tylenol 650 milligrams po every four hours PRN (as needed) for discomfort times 48 hours then consult with MD." LPN #4 was asked what should have been done after the 48 hour period. LPN #4 stated if the Tylenol had taken care of the resident's discomfort then she would fax the physician to let him know but she would call the physician if the resident was still experiencing pain. LPN #4 stated the physician didn't need to be notified if the Tylenol was "doing the trick" and the order just should have been discontinued.

On 8/17/16 at 3:00 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 was asked to read the above physician's order. RN #2 stated the order documented, "Tylenol 650 milligrams po every four hours PRN for discomfort times 48 hours then notify MD." RN #2 was asked what should have been done after the 48 hour period. RN #2 stated, "According to this (the physician's order), notify the MD. We typically reassess to see if the pain has diminished, resolved or gotten worse."

On 8/17/16 at 5:15 p.m., ASM (administrative...
F 157 Continued From page 10 staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Notification of Physicians for Clinical Problems" failed to document information regarding the above concern.

No further information was presented prior to exit.

(1) This information was obtained from the website:
https://medlineplus.gov/druginfo/meds/a681004.htm

(2) "Dementia is not a specific disease. It is a descriptive term for a collection of symptoms that can be caused by a number of disorders that affect the brain. People with dementia have significantly impaired intellectual functioning that interferes with normal activities and relationships. They also lose their ability to solve problems and maintain emotional control, and they may experience personality changes and behavioral problems, such as agitation, delusions, and hallucinations..." This information was obtained from the website:
http://www.ninds.nih.gov/disorders/dementias/dementia.htm

(3) "Osteoarthritis is the most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine." This information was obtained from the website:
https://medlineplus.gov/osteoarthritis.html

(4) "Gout is a common, painful form of arthritis. It causes swollen, red, hot and stiff joints." This information was obtained from the website:
https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-
The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the investigation.

F 225 Investigation/Report

1. Resident # 12's bruise resolved without complication.

2. All current residents will have a body check conducted to ensure there are no bruises of unknown origin.

3. The Director of Nursing and Administrator will be educated by the corporate VP of Clinical Services on completing thorough investigations of injuries of unknown origin and proper reporting.

4. Injuries of unknown origin will be reviewed daily (Monday through Friday) for 3 months by the DON or designee to ensure a thorough investigation was conducted and reported if needed. Audit results will be brought to the facility quarterly quality assurance meeting.

5. Corrective action will be accomplished on October 1, 2016.
F 225 Continued From page 12
incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to immediately report and conduct a thorough investigation for an injury of unknown origin for one of 25 residents in the survey sample, Resident #12.

The facility staff failed to report an injury of unknown origin to the state office and was unable to provide documentation of a complete investigation for a bruise to the left cheek and left eye found on Resident #12 on 5/9/16.

The findings include:

Resident #12, a 91 year old female, was admitted to the facility on 8/26/10 with a readmission date of 9/24/10, with diagnoses that included, but were not limited to; dementia, depression, macular degeneration (disease of the eyes causing blindness), anxiety, anemia (a low red blood cell count), high blood pressure, atrial fibrillation (a dyshytmia of the heart) and kidney failure.

Resident #12's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 5/22/16. Resident #12 was coded on the Brief Interview of Mental Status as unable to answer the questions, the staff assessment coded Resident #12 as being cognitively severely impaired for daily decision making.
A review of Resident #12's clinical record revealed, in part, the following nurses' note dated 5/9/16 at 4:00 p.m. "Nursing review as it relates to resident (Resident #12) with bruising to her right eye, per resident's RP (responsible party) (name of rp) "Every time I come to visit (name of Resident #12) she is playing with her doll baby, I think she probably accidently hit herself in the face with the doll, that doll's head is pretty darn hard" this writer went into resident's room and assessed the doll baby. Dolls head was very hard. Recommendation is to discard of resident's doll with rp's permission, replace with stuffed animal, softer baby dolls, monitor bruising for resolution (sic.) and fill rummage station with soft baby dolls as (name of Resident #12) loves to rummage when she is up in her wheelchair."

A review of Resident #12's comprehensive care plan dated 5/9/16 revealed, in part, the following documentation: "Problem: Skin. Resident on 5/8/16 was noted with bruising to left cheek and eye area, Resident probably hit herself in eye with doll baby. Resolved. Goal: 5/9/16. Bruising will resolve without complications thru (sic) 6/9/16. Approach: 5/9/16: Assess for pain, medicate prn (as needed) monitor bruising for resolution (sic.). Offer resident soft baby doll or stuffed animals as an option. Keep MD (medical doctor) /rp informed of changes in residents (sic) condition."

Further review of Resident #12's clinical record did not reveal any further documentation.

On 8/17/16 at 10:50 a.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2
F 225 Continued From page 14

was asked to provide an investigation for the incident where Resident #12 was found to have a bruise on her left cheek and left eye. ASM #2 stated, "This was wrapped up in the nurses' note, we did not do any other investigation regarding the incident." ASM #2 was asked whether or not the incident causing the bruise to Resident #12's face was witnessed, ASM #2 stated that it was not. ASM #2 was asked if the injury was of an unknown origin what should have been done. ASM #2 stated, "It should be documented in the nurses' note, an incident report should be completed and witness statements should be obtained, if the incident was not witnessed there should be discussions with the staff around the time the injury occurred." ASM #2 was asked if she could provide an incident report and staff interviews regarding the incident. ASM #2 asked to see what she might have in her office.

On 8/17/16 at 3:00 p.m. ASM #2 approached this surveyor and stated that the only documentation regarding the incident with Resident #12 on 5/8/16 was the nurses' note entered on 5/9/16 which described the likely cause. ASM #2 was asked to describe again the process for investigating an injury of unknown origin. ASM #2 stated, "An injury of unknown origin should be investigated and documented. We should interview anyone who had any interaction with the resident within 72 hours of the approximate time of injury. A FRI (facility reported incident) should be sent to the state office while the investigation is ongoing." ASM #2 was asked whether any of this occurred after nursing noted the bruising to Resident #12's left cheek and left eye. ASM #2 stated, "No." ASM #2 was asked what was done in regards to the injury. ASM #2 stated, "We talked to staff and family about the trauma to the
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eye area. At that time (name of Resident #12) was carrying a solid baby doll around. She had been observed hitting herself with the doll. I do not have any documentation that shows the investigative process. I do not have any documentation."

A review of the facility policy titled "Facility Internal Investigations of Abuse, Neglect and Misappropriation of Resident Personal Property" revealed, in part, the following documentation: "Principal: Nursing facility residents shall be free from abuse, neglect, corporal punishment, involuntary seclusion and misappropriation of resident personal property. Injuries of Unknown Source or Origin: A resident's injury should be classified as an "injury of unknown source" when both of the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident AND the injury is suspicious because of the location of the injury. Injuries of unknown origin are to be reported and investigated the same as an incident of mistreatment. NOTE: The facility is not relieved of its responsibility to report and investigate the occurrence, regardless of the circumstances, and complete a report."

On 8/17/16 at 5:20 p.m., ASM #1, the administrator was made aware of the above findings. No further information was provided prior to the end of the survey process. 488.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit

1. Resident # 12's bruise resolved without complication.
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<td>mistreatment, neglect, and abuse of residents and misappropriation of resident property.</td>
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This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement abuse policies for an injury of unknown origin for one of 25 residents, Resident #12.

The facility staff failed to report an injury of unknown origin to the state office and was unable to provide documentation of a complete investigation for a bruise to the left cheek and left eye found on Resident #12 on 5/9/16.

The findings include:

Resident #12, a 91 year old female, was admitted to the facility on 8/26/10 with a readmission date of 9/24/10, with diagnoses that included, but were not limited to; dementia, depression, macular degeneration (disease of the eyes causing blindness), anxiety, anemia (a low red blood cell count), high blood pressure, atrial fibrillation (a dysrhythmia of the heart) and kidney failure.

Resident #12's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 5/22/16. Resident #12 was coded on the Brief Interview of Mental Status as unable to answer the questions; the staff assessment coded Resident 12 as being cognitively severely impaired for daily decision making.

2. All current residents will have a body check conducted to ensure there are no bruises of unknown origin.

3. The Director of Nursing and Administrator will be educated by the corporate VP of Clinical Services on completing thorough investigations of injuries of unknown origin and proper reporting.

4. Injuries of unknown origin will be reviewed daily (Monday through Friday) for 3 months by the DON or designee to ensure a thorough investigation was conducted and reported if needed. Audit results will be brought to the facility quarterly quality assurance meeting.

5. Corrective action will be accomplished on October 1, 2016.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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A review of Resident #12's clinical record revealed, in part, the following nurses' note dated 5/9/16 at 4:00 p.m. "Nursing review as it relates to resident (Resident #12) with bruising to her eye, per resident's RP (responsible party) (name of rp) "Every time I come to visit (name of Resident #12) she is playing with her doll baby, I think she probably accidently hit herself in the face with the doll, that doll's head is pretty darn hard" this writer went into resident's room and assessed the doll baby. Dolls head was very hard. Recommendation is to discard of resident's doll with rp's permission, replace with stuffed animal, softer baby dolls, monitor bruising for resolution (sic.) and fill rummage station with soft baby dolls as (name of Resident #12) loves to rummage when she is up in her wheelchair."

A review of Resident #12's comprehensive care plan dated 5/9/16 revealed, in part, the following documentation: "Problem: Skin. Resident on 5/8/16 was noted with bruising to left cheek and eye area, Resident probably hit herself in eye with doll baby. Resolved. Goal: 5/9/16. Bruising will resolve without complications thru (sic) 6/9/16. Approach: 5/9/16: Assess for pain, medicate prn (as needed) monitor bruising for resolution (sic.). Offer resident soft baby doll or stuffed animals as an option. Keep MD (medical doctor) /rp informed of changes in residents (sic) condition."

Further review of Resident #12's clinical record did not reveal any further documentation.

On 8/17/16 at 10:50 a.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked to provide an investigation for the
**NAME OF PROVIDER OR SUPPLIER:**
BROOKSIDE REHAB & NURSING CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
614 HASTINGS LANE
WARRENTON, VA 20186

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<td>F 226</td>
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<td>incident where Resident #12 was found to have a bruise on her left check and left eye. ASM #2 stated, &quot;This was wrapped up in the nurses' note, we did not do any other investigation regarding the incident.&quot; ASM #2 was asked whether or not the incident causing the bruise to Resident #12's face was witnessed, ASM #2 stated that it was not. ASM #2 was asked if the injury was of an unknown origin what should have been done. ASM #2 stated, &quot;It should be documented in the nurses' note, an incident report should be completed and witness statements should be obtained, if the incident was not witnessed there should be discussions with the staff around the time the injury occurred.&quot; ASM #2 was asked if she could provide an incident report and staff interviews regarding the incident. ASM #2 asked to see what she might have in her office.</td>
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On 8/17/16 at 3:00 p.m. ASM #2 approached this surveyor and stated that the only documentation regarding the incident with Resident #12 on 5/8/16 was the nurses' note entered on 5/9/16 which described the likely cause. ASM #2 was asked to describe again the process for investigating an injury of unknown origin. ASM #2 stated, "An injury of unknown origin should be investigated and documented. We should interview anyone who had any interaction with the resident within 72 hours of the approximate time of injury. A FRI (facility reported incident) should be sent to the state office while the investigation is ongoing." ASM #2 was asked whether any of this occurred after nursing noted the bruising to Resident #12's left cheek and left eye. ASM #2 stated, "No." ASM #2 was asked what was done in regards to the injury, ASM #2 stated, "We talked to staff and family about the trauma to the eye area. At that time (name of Resident #12)
**F 226** Continued From page 19
was carrying a solid baby doll around. She had been observed hitting herself with the doll. I do not have any documentation that shows the investigative process. I do not have any documentation."

A review of the facility policy titled "Facility Internal Investigations of Abuse, Neglect and Misappropriation of Resident Personal Property" revealed, in part, the following documentation: "Principle: Nursing facility residents shall be free from abuse, neglect, corporal punishment, involuntary seclusion and misappropriation of resident personal property. Injuries of Unknown Source or Origin: A resident's injury should be classified as an "injury of unknown source" when both of the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident, AND The injury is suspicious because of the location of the injury. Injuries of unknown origin are to be reported and investigated the same as an incident of mistreatment. NOTE: The facility is not relieved of its responsibility to report and investigate the occurrence, regardless of the circumstances, and complete a report."

On 8/17/16 at 5:20 p.m. ASM #1, the administrator was made aware of the above findings. No further information was provided prior to the end of the survey process.

**F 253 Housekeeping and Maintenance.**

1. The identified ceiling tiles were replaced, the floor tile on NW was corrected, and the shower stalls were repaired on 8-17-2016. The three shower room doors will be replaced.
F 253 Continued From page 20

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, it was determined that the facility staff failed to provide maintenance services necessary to maintain an orderly and comfortable interior on Two of two units (North unit and South unit) and in three of three shower rooms (one of one North unit shower room and two of two South unit shower rooms).

The facility staff failed to maintain 52 ceiling tiles on two of two units [North unit and South unit], one floor tile (on the North unit), three shower room doors (one of one shower room door on the North unit and two of two shower room doors on the South unit) and two shower stalls in good repair in one of one shower room on the North unit.

The findings include:

On 8/17/16 at 11:05 a.m. a general observation tour of the facility was conducted. The following was observed:

52 ceiling tiles were stained with a black and or brown substance.
One broken floor tile (exposing concrete floor) was observed in the threshold of room 144.
The bottom third of the outside face of the North unit shower room door was chipped and pitted.
The bottom half of the edge of the shower room door was cut and chipped, revealing gouges on the door edge.
Chipped tile was observed on the corner of the

F 253

2. An initial audit of the ceiling tiles and shower rooms for proper working order will be completed by the Administrator, Director of Plant Operations or designee.

3. The Environmental Service Department and Plant Operations Department will be educated on proper reporting with work orders any stained ceiling tiles, or shower room repairs needed.

4. A weekly audit will be conducted for 3 months to ensure that the shower rooms are maintained properly and are in good repair and that ceiling tiles are not wet or stained. The audit results will be brought to the facility quarterly quality assurance meeting.

5. Corrective Action will be accomplished on October 1, 2016.
(F 253) Continued From page 21
far left shower stall and far right shower stall located in the North unit shower room.
The bottom third of edge of both South unit shower room doors were cut and chipped,
revealing gouges on the door edges.
Paint was chipped on the frame that contacted the South unit shower room door that was located
in the same hall as rooms 130 to 134.

On 8/17/16 at 11:55 a.m., an interview was
carried out with OSM (other staff member) #3 (the
maintenance director). OSM #3 confirmed the
maintenance department was responsible for all
of the above concerns. OSM #3 stated facility
staff is supposed to write work orders for
maintenance concerns. OSM #3 was made
aware of the above concerns. In regards to the
ceiling tiles, OSM #3 stated his staff constantly
replaces the ceiling tiles (Note- staff was observed replacing ceiling tiles during the
survey). OSM #3 stated the stained ceiling tiles resulted from the condensation from the air
conditioning unit and water lines. OSM #3 stated
the new facility owners were working on
proposals to replace the unit. At this time, OSM
#3 was asked to tour the facility with this
surveyor. OSM #3 was shown stained ceiling
tiles. OSM #3 was shown the broken floor tile in the threshold of room 144. OSM #3 measured
the broken area and it was approximately two
inches long by two and a half inches wide. OSM
#3 stated he wasn't aware of the broken floor tile.
OSM #3 was shown the North shower room door;
OSM #3 stated he would call and get a price to
replace the door. OSM #3 was shown the North
unit shower stalls that contained chipped tiles.
The chipped area in the far left shower stall measured approximately five eighth of an inch
long by two and a half inches wide with exposed
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| F 253 | Continued From page 22
mortar. The chipped area in the far right shower stall measured approximately one and a half inch long by one inch wide. OSM #3 was shown both shower room doors on the South unit and the chipped paint on the frame of the shower room door that was located in the hall by rooms 130 to 134. OSM #3 was asked to provide a facility policy regarding the above concerns.
On 8/17/16 at 12:25 p.m., OSM #3 presented a blank maintenance work order form. OSM #3 stated he trains staff to fill out the work order forms and place the forms in the maintenance box.
On 8/17/16 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator and ASM #2 (the director of nursing) were made aware of the above findings. A maintenance policy was requested.
On 8/18/16 at 8:10 a.m., ASM #1 stated the facility did not have a maintenance policy.

F 274 | 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE
A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident’s physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident’s status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical practices.)

F274: Comprehensive Assessment after Significant Change

1) On 8/17/16 a Significant change assessment was opened for resident #9 with an ARD of 8/23/16. Completion date was 8/29/16.
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<td>F 274</td>
<td>Continued From page 23 interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to complete a significant change MDS (minimum data set) assessment for one of 25 residents in the survey sample. (Resident #9).</td>
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<td>Resident #9's 7/31/16 quarterly MDS assessment should have been a significant change MDS assessment.</td>
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<td>The findings include: Resident #9 was admitted on 4/21/16 with the diagnoses of but not limited to dementia, depression, Alzheimer's disease, and insomnia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/31/16. The resident was coded as severely cognitively impaired in ability to make daily life decisions, and was unable to complete the BIMS (Brief Interview for Mental Status) exam interview and therefore the staff assessment for cognition was completed. Resident #9 was coded as requiring total care for bathing, hygiene, dressing, and transfers; extensive assistance for ambulation; supervision for eating; and was coded as incontinent of bowel and bladder.</td>
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2) Audits will be conducted on residents that are due for an OBRA assessment, before the assessment is closed out. The assessment will be compared with the prior OBRA assessment to see if a significant change assessment is warranted. Audits will be conducted by the MDS nurse, DON, or designee. Audits will be conducted on 100% of residents weekly x 4 weeks.

3) On 8/17/16, MDS nurses reviewed criteria in the RAI manual in regards to when a significant change assessment should be completed. Online education was also viewed by MDS nurses on 8/18/16. IDT will discuss residents that are coming up for OBRA assessment at the weekly CMI meeting, to see if they are showing a significant decline or improvement in status.

4) Audits will be conducted on residents that are due for an OBRA assessment, before the assessment is closed out. The assessment will be compared with the prior OBRA assessment to see if a significant change assessment is warranted. 50% of assessments weekly x 2 weeks and then 25% x 2 weeks. Results of audits will be brought to the Quarterly Quality Assurance meeting.

5) Corrective action will be completed October 1, 2016.
**F 274** Continued From page 24

A review of the May 1, 2016 Admission MDS, and the July 31, 2016 quarterly MDS revealed multiple changes in the resident's status, and that the July 31, 2016 MDS should have been a significant change MDS, instead of a quarterly MDS.

The changes identified are as follows:

- BIMS; On May 1, 2016 was a 3; On July 31, 2016, the resident was not even able to complete this assessment as her cognition had declined.
- Mood; On May 1, 2016 the resident's mood score was a 3. On July 31, 2016, the resident's mood score was 13. This was a decline.
- Bed mobility; On May 1, 2016 the resident was coded as 2/2 (required limited assistance); On July 31, 2016 the resident was coded as 4/2 (required total assistance.) This was a decline.
- Transfer; On May 1, 2016 the resident was coded as 2/2 (required limited assistance); On July 31, 2016 was coded as 3/2 (required extensive assistance.) This was a decline.
- Walk in room; On May 1, 2016 the resident was coded as 2/2 (required limited assistance); On July 31, 2016 was coded as 3/2 (required extensive assistance.) This was a decline.
- Walk in corridor; On May 1, 2016 the resident was coded as 2/2 (required limited assistance); On July 31, 2016 was coded as 3/2 (required extensive assistance.) This was a decline.
- Dressing; On May 1, 2016 the resident was coded as 2/2 (required limited assistance); On July 31, 2016 was coded as 4/2 (required total assistance.) This was a decline.
- Hygiene; On May 1, 2016 the resident was coded as 2/2 (required limited assistance); On July 31, 2016 was coded as 4/2 (required total assistance.) This was a decline.
- Bathing; On May 1, 2016 the resident was coded
F 274 Continued From page 25
as 3/2 (required extensive assistance); On July 31, 2016 was coded as 4/2 (required total assistance.) This was a decline.
Bowel elimination; On May 1, 2016 the resident was coded as 1 (occasionally incontinent); On July 31, 2016 the resident was coded as 2 (frequently incontinent.) This was a decline.
Bladder elimination; On May 1, 2016 the resident was coded as 1 (occasionally incontinent.) On July 31, 2016 the resident was coded as 3 (always incontinent.) This was a decline

On 8/17/16 at 9:45 a.m., LPN #2, (Licensed Practical Nurse, the MDS nurse) stated that a significant change MDS should have been done.

On 8/17/16 at 4:41 p.m., LPN #2 was asked about a facility policy for completing the MDS. She stated the facility follows the RAI manual (Resident Assessment Instrument.)

A review of the RAI manual, Version 3.0, October 2015, documented on pages 2-22 to 2-24, "Some Guidelines to Assist in Deciding if a Change is Significant or Not.....Decline in two or more of the following: - Resident’s decision-making changes; - Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency...; - Any decline in an ADL physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment; - Resident s incontinence pattern changes or there was placement of an indwelling catheter..."

On 8/17/16 at 4:53 p.m., the Administrator and Director of Nursing were made aware of the findings. No further information was provided by
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<td>F 274</td>
<td>Continued From page 26 the end of the survey.</td>
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<td>F 280</td>
<td>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</td>
<td>F 280</td>
<td>F280: Participate Planning Care- Revise CP</td>
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<td>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</td>
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<td>1) On 8/17/16 a fall mat was re-instated on resident # 10.</td>
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<td>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</td>
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<td>2) A 100% audit for all current residents will be completed of resident care cards for accuracy of fall mats and care plans relating to fall mats.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>3) Nursing staff will be educated on updating care plans and care cards when a new order is received to discontinue fall mats. Nursing will also put information on the 24hr. report, so that it can be reviewed by nurse management during SOC.</td>
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<td>Based on observation, staff interview, clinical record review and facility document review, it was determined that facility staff failed to revise the comprehensive care plan for one of 25 residents in the survey sample, Resident #10.</td>
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<td>4) Audits will be conducted by MDS nurse, DON, or designee, on care plans of residents that have had new orders to start or discontinue a treatment. They will be conducted, 100% weekly x 1 month and then 50% bi-weekly x 1 month. Results will be reported at the quarterly Quality Assurance meeting.</td>
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<td>The facility staff failed to revise Resident #10's comprehensive care plan after an order was written to discontinue the use of a fall mat on 4/24/16.</td>
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<td>5) Corrective actions will be completed October 1, 2016.</td>
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F 280 Continued From page 27

The findings include:

Resident #10 was admitted to the facility on 1/21/14 and readmitted on 8/31/15 with diagnoses that included but were not limited to: seizures, major depressive disorder, osteoarthritis, dementia with behavioral disturbance, high blood pressure, muscle wasting, atrophy and weakness.

Resident #10's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/24/16. Resident #10 was coded as being severely cognitively impaired in the ability to make daily decisions scoring three out of 10 on the BIMS (brief interview for mental status) exam. Resident #10 was coded as being totally dependent on staff with most ADLS (activities of daily living) and extensive assistance with meals.

Review of Resident #10's fall care plan dated 9/1/15 and updated 7/28/16, revealed the following intervention: "Fall mat beside bed when in bed."

Review of Resident #10’s care card (Kardex used for the CNA [Certified Nursing Assistant]) documented the following: "Equipment used:" A check mark was placed in the box next to "Fall Mat" indicating that Resident #10 needed a fall mat in place. Resident #10 was also coded as requiring a mechanical lift for transfers and log roll with two persons for bed mobility. She was coded as being non-ambulatory.

Review of Resident #10's POS (physician order sheet) dated, 7/01/16 through 7/31/16.
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Continued From page 28
documented the following: "9/03/15 Fall mat at beside while in bed every shift D/c'd (discontinued) 4/24/16."

The following nurse's note was written on 4/24/16: "10 a.m. Fall mat at beside dc'd d/t (due to) resident does not move in bed, zero fall OOB (out of bed). Message left to RP (responsible party) to call (name of facility)."

Review of the clinical record for the last 6 months revealed no incidents of falls.

On 8/17/16 at 4:09 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the unit manager of the Alzheimer's unit. When asked the purpose of the care plan she stated that it was used to direct care from A to Z. She stated that a care plan should address all the needs of a resident so that a stranger walking in would know how to care for that resident. When asked how CNA's know what interventions to put into place, LPN #1 stated that the CNA's can look at the care cards that are created from the care plans. When asked who updates the care cards, LPN #1 stated that the lead CNA, the nurses, or she would update the care plan. When asked when the care plan would be updated, LPN #1 stated for any changes in condition. When asked if Resident #10 needed a fall mat in place, LPN #1 stated, "A fall mat wouldn't hurt."

On 8/17/16 at 4:45 p.m., Resident #10 was observed sleeping in bed. Her nursing aide was observed bringing the mechanical lift into her room with another nursing aide. They were about to get Resident #10 up for dinner. Resident #10 did not have a fall mat in place while she was in bed. There was no fall mat present in her room.
F 280  Continued From page 29

When CNA #3 was asked how she would know if a resident needed a fall preventive measure in place, CNA #3 stated that it would be on the ADL care card. When asked who updates the care card, CNA #3 stated the nursing aides can update it after the nurse verbally instructs them to do so or the nurses change the care card. When asked to see the care card, CNA #3 opened Resident #10’s closet drawer. A check was mark was placed in the box next to option “fall mat” indicating that Resident #10 needed a fall mat in place. When asked if Resident #10 was supposed to have a fall mat in place, CNA #3 stated that she did not have the resident on a regular basis and was not sure if the resident needed a fall mat.

On 8/18/16 at 8:21 a.m., further interview was conducted with LPN #1. She stated that the order for the fall mat was discontinued in April of 2016 and that the intervention should not have been on the care plan. When asked if the care plan is also revised with new orders, LPN #1 stated, “Not for every order, but if there was an order to discontinue the fall mat then I would have revised the care plan.”

On 8/18/16 at approximately 9:00 a.m., an interview was conducted with LPN #10, Resident #10’s nurse for that shift. When asked if Resident #10 was a fall risk, she stated, “I don’t believe so.” When asked if the resident was supposed to have a fall mat in place, LPN #10 stated, “I would have to check.” When asked what she would check to find out this information, LPN #10 stated that she would check the care plan. When asked when the care plan would be revised or updated, LPN #10 stated that it would be updated after a change in treatment or after
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>(X3) DATE SURVEY COMPLETED</th>
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**NAME OF PROVIDER OR SUPPLIER**

BROOKSIDE REHAB & NURSING CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

614 HASTINGS LANE
WARRENTON, VA 20186

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<th>PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>F 280</td>
<td>Continued From page 30 an incident. When asked what it meant if there was an order to discontinue the use of a fall mat but it was still on the care plan, LPN #10 stated that it looked like the care plan was not updated by removing the intervention for the fall mat. On 8/18/16 at 10:15 a.m., ASM (administrative staff member) #2, the DON (Director of Nursing) was made aware of the above concerns. She stated that staff always refers to the care plan or care card and that it should have been updated. The facility policy titled, &quot;Using the Care Plan&quot; documents, in part, the following: &quot;The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident...5. Changes in the resident's condition must be reported to the MDS Assessment Coordinator so that a review of the resident's assessment and care plan can be made.&quot; No further information was provided prior to exit. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review and clinical record review, it was determined that facility staff failed to follow professional standards for two of 25 residents in the survey sample, Resident #8 and Resident #6.</td>
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<td>F 281</td>
<td>1. The bilateral soft palm guards for resident #8 were applied effective 8/18/16. Skin checks were done and no pressure or skin irritation noted. Resident is tolerating the palm guards with no pain or discomfort noted. Pain and skin assessments have been updated. Physician's order has been obtained for bilateral soft palm guards to be applied when up out of bed, every shift skin checks for skin integrity.</td>
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**483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS**

The services provided or arranged by the facility must meet professional standards of quality.
The standing sliding scale insulin order signed by the MD on 7/27/16 for resident #6 indicates that a finger stick blood sugar ranging between 149-376 would require no repeat finger stick or MD notification. The use of a (:) semi-colon in the order, as printed on the MAR created confusion as to the interpretation of this order by the nurses.

2. An audit of 100% of residents with order for splints will be done by the DON, ADON, UM, or designee. Audits to include whether splints ordered are being applied and removed as ordered and documentation by nurses is accurate.

An audit of 100% of residents with sliding scale insulin orders will be done by the DON, ADON, UM or designee to ensure orders were followed with repeat finger sticks obtained and/or MD notification per order.

3. All professional staff (RN’s and LPN’s) will be educated on the standards of documentation. The standing sliding scale insulin order will be revised to be more clearly understood by all who read this order. The pharmacy will clearly document on the pre-printed MAR’s when repeat finger sticks are to be done, the time frame in which repeat finger sticks are to be done, and when MD notification is to occur. All professional staff (RN’s and LPN’s) will be educated on the standing sliding scale insulin orders.
F 281 Continued From page 32
resting in her lap. Her fingers were contracted towards the palms with the right finger tips touching the palm. There were no palm guards on.

On observation was made on 8/16/16 at 4:50 p.m. The resident was in bed with her eyes closed she did not have palm guards on her hands.

An observation was made on 8/17/16 at 7:36 a.m. Resident #8 was lying in bed with the head of bed elevated, her eyes were closed. There were no palm guards on at that time.

An observation was made on 8/17/16 at 11:22 a.m. The resident was up in a geri chair in the day room. There were no palm guards on her hands.

An observation was made on 8/17/16 at 12:50 p.m. The resident was up in a geri chair in the dining room. There were no palm guards on her hands.

Review of the physician's orders signed and dated on 8/1/16 documented, "02/08/16: APPLY BIL (bilateral) HAND SOFT GUARDS AND REMOVE EVERY 2 HOURS TO CHECK SKIN INTEGRITY."

Review of the resident's August 2016 treatment administration record documented, "APPLY BIL HAND SOFT PALM GUARDS AND REMOVE EVERY TWO HOURS TO CHECK SKIN INTEGRITY." On each day of observation 8/16 and 8/17/16, for each shift the staff documented that the soft hand guards were on Resident #8.

4. A list of all residents with orders for splints will be developed and maintained by the MDS Coordinators. 10% of the residents on this list will be audited by the Restorative Nurse Aid or designee monthly times three months.

10% of residents with sliding scale insulin orders will be audited by DON, ADON, UM or designee monthly times three months.

Results of audits will be presented to the Quarterly Quality Assurance Committee Meeting.

5. Corrective action will be completed October 1, 2016.
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Review of the care plan initiated on 2/19/15 and reviewed on 6/9/16 documented, "ADL's (activities of daily living) -- Resident is total dependent for her ADL's...she has hand palm guard for contracture management of her right hand. Interventions: apply palm guard to right hand for contracture management remove q (every) 2hr (hours) to check skin integrity as she will allow/tolerate."

Resident #8's nurses notes from 4/25/16 to 8/16/16, were reviewed and revealed no evidence of documentation that the palm guards were on the resident's hands. On 8/15/16 at 10:30 a.m. the nurse's notes documented "BUE (both upper extremities)/BUE (both lower extremities) contractures."

Review of the monthly summary dated 8/8/16 documented, "O Special Treatments. Splint/brace assistance."

On 8/17/16 at 12:20 p.m. an interview was conducted with LPN (licensed practical nurse) #6, the nurse caring for Resident #8. When asked if the resident had palm guards, LPN #6 stated, "We haven't used the splint in a long time. It's excruciating for her to put the soft palm guard on. We generally put a wash cloth in her hands. We should get that order d/c'd (discontinued)." LPN #6 was asked to review Resident #8's treatment administration record for the palm guards documenting the hand guards were in place. LPN #6 was then asked if the documentation was accurate. LPN #6 stated, "No, we should be documenting the rolled washcloths as tolerated. When asked if it was a nursing standard of practice to document something that wasn't accurate, LPN #6 stated, "It's just one of those
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<td>F 281</td>
<td>Continued From page 34 things that gets over looked.&quot;</td>
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On 8/17/16 at 4:10 p.m., an interview was conducted with RN (registered nurse) #1, the assistant director of nursing. When asked if staff should document each shift that Resident #8’s palm guard was in place when it was not, ASM #4 stated, "It shouldn’t be, no. Absolutely not. It should have been discontinued a long time ago. If the palm guard was not on they should have circled it and documented the reason on the back."

On 8/17/16 at 5:45 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

On 8/18/16 at 10:20 a.m., the facility nursing standard for documentation was requested from ASM #2, the director of nursing and provided.

Review of the facility's nursing standard for practice from Lippincott, Chapter 2 page 16 titled, "STANDARDS OF CARE AND ETHICAL AND LEGAL ISSUES" documented, "Standards of Practice General Principles. 1. The practice of professional nursing has standards of practice setting minimum levels of acceptable performance for which its practitioners are accountable. b. These standards provide patients with a means of measuring the quality of care they receive. 5. A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions and reasons for the care provided, including any apparent deviate. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events."
No further information was provided prior to exit.

"Don't alter a client's record, this is a criminal offense. Never add information at a later date without indicating that you did so. Never document anything that you did not do."

Lippincott Williams and Wilkins Fundamentals of Nursing 2007 page 53.

According to Fundamentals of Nursing, Lippincott Williams and Wilkins Philadelphia 2007 page 53. "Accurate documentation shows the care that you (nurses) provide meets the patient's needs and expressed wishes. It proves you are following the accepted standards of nursing care mandated by the law, your profession, and your health care facility..." and on page 93, "The medical record is the main source of information and communication among nurses, doctors, physical therapists, social workers, and caregivers. Everyone's notes and documentation is important because together they represent a complete picture of the patient's care."

2. Resident #6 was admitted to the facility on 12/29/12 and readmitted on 8/13/15 with diagnoses that included but were not limited to: urinary tract infection, diabetes, high blood pressure, dementia, kidney disease and elevated cholesterol.

The most recent MDS, an annual assessment, with an ARD of 6/29/16 coded that the resident as having an 11 out 15 on the BIIMS (brief interview for mental status) indicating the resident was moderately impaired cognitively to make daily
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decisions. Resident #6 was coded as requiring
assistance from staff for all activities of daily
living.

Review of the physician's orders signed and
dated on 7/27/16 documented, "INSULIN R (1)
100UNIT/1ML (milliliter) INJECT EVERY 6
HOURS SUBCUTANEOUSLY PER SLIDING
SCALE F.S. (finger stick) 61-150 NO
INTERVENTION NECESSARY, 151-200 = 2
UNITS, 201-250 = 4 UNITS, 251-300 = 6 UNITS,
301-350 = 8 UNITS, 351-400 = 10 UNITS,
401-450 = 12 UNITS, 451-500 = 14 UNITS;
REPEAT IN 3 HRS AND CONTINUE SLIDING
SCALE AS ABOVE, IF F.S. IS OVER 500 CALL
MD...."

Review of the August 2016 MAR (medication
administration record) documented, "INSULIN R
100UNIT/1ML (milliliter) INJECT EVERY 6
HOURS SUBCUTANEOUSLY PER SLIDING
SCALE F.S. (finger stick) 61-150 NO
INTERVENTION NECESSARY, 151-200 = 2
UNITS, 201-250 = 4 UNITS, 251-300 = 6 UNITS,
301-350 = 8 UNITS, 351-400 = 10 UNITS,
401-450 = 12 UNITS, 451-500 = 14 UNITS;
REPEAT IN 3 HRS AND CONTINUE SLIDING
SCALE AS ABOVE, IF F.S. IS OVER 500 CALL
MD...."

Review of the care plan initiated on 8/17/15 and
revised on 8/12/16 documented, "Focus. The
resident has Diabetes Mellitus. Interventions.
Diabetes medication as order by doctor.
Monitor/document for side effects and
effectiveness. Finger stick BS (blood sugar) as
ordered."

Review of the August MAR documented that
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/LIA IDENIFICATION NUMBER: 495267

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED
C. 08/18/2016

NAME OF PROVIDER OR SUPPLIER

BROOKSIDE REHAB & NURSING CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
614 HASTINGS LANE
WARRENTON, VA 20186

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Resident #6 received insulin according to the sliding scale insulin order for blood sugars ranging from 155 to 376 four times a day from 8/1/16 to 8/17/16 except on 8/7/16 at 6:00 p.m. when the resident’s blood sugar was 149. The review did not evidence documentation that the resident had a follow up fingerstick blood sugar checked on any occasion.

An interview was conducted on 8/17/16 at 3:40 p.m. with LPN (licensed practical nurse) #8, the resident’s day shift nurse, LPN # 9, a new nurse in orientation and RN (registered nurse) # 4, the residents evening shift nurse. When asked to review the physician’s sliding scale insulin order and to explain what actions the nurse should take, LPN #8 stated, “If it’s over 500 then do a fingerstick in three hours.” RN #4 stated, “But it says 451 to 500; that’s when I would do it.” LPN #9 stated, “It’s not really clear. If I had any questions I would be calling the doctor and get a clarifying order.”

An interview was conducted on 8/17/16 at 3:45 p.m. with LPN #3, the unit manager. When asked to review the sliding scale insulin order and to explain what actions the nurse’s would take, LPN #3 stated, “It’s confusing.”

An interview was conducted on 8/17/16 at 3:50 p.m. with RN #1, the assistant director of nursing. RN #1 was asked to review the sliding scale insulin order and to explain what actions a nurse take. RN #1 stated, “For me, if you have to give 14 units (for example) you would repeat the fingerstick in three hours.”

An interview was conducted on 8/17/16 at 5:32 p.m. with ASM (administrative staff member) #2,
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the director of nursing. ASM #2 was asked to
review Resident #6’s sliding scale order and was
asked if the nurses should check the fingerstick
blood sugar whenever they gave insulin. ASM #2
reviewed the order and stated, “Oh, yes.” ASM #2
was made aware of the findings at that time.

Review of the facility’s policy on insulin
administration did not evidence documentation
regarding following a physician’s orders for sliding
scale insulin.

No further information was provided prior to exit.

483.20(k)(3)(ii) SERVICES BY QUALIFIED
PERSONS/PER CARE PLAN

The services provided or arranged by the facility
must be provided by qualified persons in
accordance with each resident’s written plan of
care.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, clinical
record review and facility document review, it was
determined that facility staff failed to provide
services in accordance with the written plan of
care for four of 25 residents in the survey sample;
Resident #12, #3, #14, and #15.

1. The facility staff failed to provide assistance
and supervision at meals as documented in the
comprehensive care plan for Resident #12.

2. The facility staff failed to follow Resident # 3’s
plan of care for administration of Donepezil (1).

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CNA #7 was educated immediately
on proper documentation of meal intake
for resident #12. The dietician was
notified of resident #12’s poor po intake
and therapy screened the resident.

A clinical incident was completed for
residents #3 and #14.

A BMP and Hgb A1C was done won
9/6/16 for resident # 15. Resident # 15
also had an A1C done January 12th,
April 15th, and June 3rd. Although no
BMP was done in January, a CMP was
drawn February 25th.
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3. The facility staff failed to follow Resident #14's care plan for the administration of insulin, Humulin (2), Polyethylene Glycol (5), Metoprolol (6), and Lantus (7).  
4. The facility staff failed to follow Resident #15's care plan initiated on 7/16/14 and revised on 7/12/16 to obtain laboratory specimens as ordered by the physician.  
The findings include:  
1. The facility staff failed to provide assistance and supervision at meals as documented in the comprehensive care plan for Resident #12.  
Resident #12, a 91 year old female, was admitted to the facility on 8/26/10 with a readmission date of 9/24/10 with diagnoses that included, but were not limited to dementia, depression, macular degeneration (disease of the eyes causing blindness), anxiety, anemia (a low red blood cell count), high blood pressure, atrial fibrillation (a dysrhythmia of the heart) and kidney failure.  
Resident #12's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/22/16. Resident #12 was coded on the Brief Interview of Mental Status as unable to answer the questions, the staff assessment coded Resident #12 as being cognitively severely impaired for daily decision making. Resident #12 was also coded as requiring limited assistance of one person with physical assist for eating.  
Resident #12 was observed at meals in her room without assistance or supervision on the following dates and times: | 2. An initial audit of all residents identified as requiring verbal cueing or assistance with eating will be audited to identify that appropriate assistance is provided and that meal intake percentage is accurately documented. This audit will be done by the MDS Coordinators, Supervisors, or designee.  
A 100% audit of MAR's/TAR's will be done initially to ensure documentation is present. Audits to be done by the Unit Manager, Supervisor, or designee  
An initial audit of all ordered labs since 8/1/16 will be done by the DON, ADON, UMs, or designee to ensure labs were drawn as ordered and results are on Medical Record. |
3. Education for CNA's was initiated on 8/18 on how to accurately assess and document the percentage of meal intake, as well as how to supervise, provide verbal cuing, provide actual assistance as needed, and provide alternatives as needed. All CNA's will complete this education. New hire CNA's will be provided education during their orientation process. A communication form will be implemented for the CNA to communicate/document any resident change in PO intake to the nurse. All nursing staff will be educated on the use of this form. All professional staff (RN's and LPN's) will be educated on the standards for documentation. New hire RN's and LPN's will complete this education during their new hire orientation process.

The Pharmacy will provide monthly a listing of all residents with orders for labs. The Unit Secretaries will check this listing, fill out a lab requisition slip, place the ordered lab on our lab audit tool(s), and then check the audit tool daily (Monday through Friday) to ensure it has been crossed off the audit tool by the nurse who drew the lab. The Unit Secretaries will follow up to ensure the results of the lab are received by the facility.
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Resident #12 the milkshake, placed it on the bedside table and left the room. Resident #12 did not eat or drink any food. At 9:00 a.m., the uneaten meal tray was removed from Resident #12's room by a resident helper with no further offers of alternate foods or assistance with feeding.

A review of Resident #12's nursing notes did not reveal any documentation that Resident #12 was not eating her meals.

Further review of Resident #12's clinical record revealed, in part, a nutrition assessment dated 5/24/16 that documented, "Continue Current Plan of Care. PO (by mouth) 50 - 75%.”

A review of the meal logs for Resident #12 revealed, in part, that on the dates observed with a meal or a snack Resident #12 was documented as consuming the following percentages of her meal:
8/16/16 snack was not documented
8/17/16 breakfast consumed 0 (zero) percent
8/17/16 lunch consumed 0 percent
8/18/16 breakfast consumed 25% - This surveyor observed this meal and Resident #12 only consumed one or two teaspoons of the meal.

A review of Resident #12's comprehensive care plan dated 5/6/14 revealed, in part, the following documentation: "Problem: The resident (Resident #12) has an ADL (activities of daily living) self-care performance deficit r/t (related to) dementia, she (Resident #12) dependent mainly for her ADL care. She is able to feed herself after set up she may require assistance as she will allow. Interventions: Eating: The resident (Resident #12) requires set up assistance at

4. An audit of 5% of those identified residents requiring verbal cueing or assistance with eating will be done biweekly times two months by the MDS Coordinators, Supervisors, or designee.

MAR's/TAR's will be audited daily by the Supervisors to ensure documentation is complete. Any nurse identified as failing to complete their documentation will be called back in to complete any missing documentation. A 5% audit will be done monthly by the DON, ADON, UMs, or designee for two months.

5% of labs ordered will be audited monthly times three months by the DON, ADON, UMs, or designee. Results of the audits will be presented to the Quarterly Quality Assurance Committee Meeting.

5. Corrective Action will be completed October 1, 2016.
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Further review of Resident #12's clinical record did not reveal any documentation that the dietician had been contacted in regards to low food intake.

A review of Resident #12's Resident Care Card, posted on the inside surface of Resident #12's wardrobe, provided the following instruction: "Eating, in room and tray set up only. Resident eats better when in room."

On 8/17/16 at approximately 9:05 a.m. an interview was conducted with OSM (other staff member) #5, a resident helper. OSM #5 was asked how Resident #12 normally ate, OSM #5 stated, "She does not get assistance, she eats by herself. I'm going to take her tray (breakfast) she's (Resident #12) not going to eat it. If she's hungry she'd eat it. She will eat at lunch time." OSM #5 was asked whether or not she should attempt to feed Resident #12 when she was not feeding herself. OSM #5 stated, "I don't know, I'm not allowed." OSM #5 removed Resident #12's breakfast tray and disposed of the food. OSM #5 was observed to then go help other residents who were seated in the dining hall.

An interview was conducted with CNA (certified nursing assistant) #7 on 8/18/16 at 9:05 a.m.
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CNA #7 was asked how much Resident #12 had consumed of her breakfast. CNA #7 stated, "She (Resident #12) ate just a few bites even with me cueing her."

On 8/18/16 at 9:55 a.m. an interview was conducted with CNA #8. CNA #8 was asked if she observed a resident not eating food what would she do. CNA #8 stated, "I would assist / encourage if they can do for themselves I try to let them do as much as they can. When not eating for several days I will talk to the supervisor, either the lead CNA or the unit manager."

On 8/18/16 at 10:00 a.m. an interview was conducted with LPN (licensed practical nurse) #2, the MDS coordinator. LPN #2 was asked what nursing's responsibility was related to care plans. LPN #2 stated, "The expectation of nursing is to review the care plan and follow the directions as provided. That is the plan of care and what should be followed."

On 8/18/16 at 10:15 a.m. an interview was conducted with CNA #9. CNA #9 was asked what she should do if a resident was observed not eating a meal provided. CNA #9 stated, "I would try to encourage the resident to eat, if you give them the first bit it kind of encourages them to eat more. If a resident persisted with not eating I would sit down with the resident and I would try to help them, just encourage them to eat. If I wasn't successful I would let the nurse know that the resident was not eating." CNA #9 was asked what the concern would be if a resident wasn't eating, CNA #9 stated, "There may be something wrong with the resident, I would be concerned that the resident was not getting enough nutrition." CNA #9 was asked about Resident
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#12. CNA #8 stated, "When I've seen her (Resident #12) she will feed herself, she may use her fingers. I haven't worked with her in a couple of weeks."

On 8/18/16 at 10:17 a.m. an interview was conducted with LPN (licensed practical nurse) #12, Resident #12's care giver on the unit. LPN #12 was asked how she would know if any residents on the hallway were not eating their meals. LPN #12 stated, "The CNAs would tell me and I would go in and try to encourage the resident to eat." LPN #12 was asked if she was aware of a resident not eating her meals this week. LPN #12 stated she was not, the aides had not told her of anyone not eating. LPN #12 was asked if she was aware that Resident #12 had not been eating her meals, and had not eaten breakfast this morning. LPN #12 stated that she was not aware; the aides had not mentioned it. LPN #12 further stated, "(Name of Resident #12) often times will not eat. She does not like assistance and gets angry; she will sometimes drink the milkshake." LPN #12 was asked if she was aware of the care plan for Resident #12, LPN #12 stated that she was. LPN #12 was informed Resident #12's care plan documented that she required cues and supervision. LPN #12 was asked what cues and supervision meant. LPN #12 stated, "It means we would encourage her to eat and stop in her room to cue her." LPN #12 was asked if she had stopped in Resident #12's room during breakfast to supervise or cue her for eating. LPN #12 stated that she had not.

On 8/18/16 at 10:50 a.m. an interview was conducted with RN (registered nurse) #14. RN #14 was asked if she referenced the care plans.
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to determine a resident's plan of care. RN #14 stated, "I don't have time to get to the care plan. If it's a new resident I do review the chart a lot. The care plan is not something I refer to and I don't have the excess time to refer to them."

On 8/18/16 at 11:00 a.m. an interview was conducted with CNA #7. CNA #7 was asked about Resident #12's ability to self feed. CNA #7 stated, "(Name of Resident #12) likes to feed herself but you have to try to encourage her. You have to supervise her eating and sit with her and cue her to eat. You just have to keep trying." CNA #7 was asked if Resident #12 had eaten her breakfast this morning, CNA #7 stated that she did not. CNA #7 was asked if Resident #12 normally ate her meals, CNA #7 stated, "She doesn't understand that she needs to eat and in the last month she has become worse."

On 8/18/16 at 11:15 a.m. ASM (administrative staff member) #2, the director of nursing, was made aware of the above findings. ASM #2 was asked whether or not she was aware that Resident #12 was not eating her meals. ASM #2 stated that she was unaware that Resident #12 was not eating. ASM #2 was shown the care plan for Resident #12 and asked what "supervise and cue" meant in regards to Resident #12's meals. ASM #2 stated, "It means to observe her meal and cue her to eat her meals. There is an assigned CNA to be on that unit and supervise, make sure that the resident is eating. Supervision is walking up and down the hallway to check on the residents." ASM #2 was asked if the aides saw that Resident #12 was not eating what should be done, ASM #2 stated, "They should attempt to cue her and spoon feed as she allows. She (Resident #12) should be offered an
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alternate food and it should be documented on
the meal log."

A review of the policy titled "Using the Care Plan"
revealed, in part, the following documentation;
"Policy Statement: The care plan shall be used in
developing the resident's daily care routines and
will be available to staff personnel who have
responsibility for providing care or services to the
resident. Policy Interpretation and
Implementation: 3. CNA's are responsible for
reporting to the Nurse Supervisor any change in
the resident's condition and care plan goals and
objectives that have not been met. 6.
Documentation must be consistent with the
resident's care plan."

No further information was provided prior to the
end of the survey process.
2. The facility staff failed to follow Resident # 3's
plan of care for administration of Donepezil(1).

Resident # 3 was admitted to the facility on
6/19/15 with diagnoses that included but were not
limited to: benign prostatic hyperplasia (2), low
iron, hypothyroidism (3), and lymphocytopenia
(4).

Resident # 3's most recent comprehensive MDS
(minimum data set), an annual assessment with
an ARD (assessment reference date) of 6/22/16,
coded Resident # 3 as scoring a 10 (ten) on the
brief interview for mental status (BIMS) of a score
of 0 - 15, 10 (ten) - being moderately impaired of
cognition for making daily decisions. Resident #
3 was coded as being independent for activities
of daily living.

The "Physician's Order Sheet" dated 06/01/16
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through 08/31/16 and signed by the physician on
8/3/16 documented, "Donepezil 5 MG (milligram)
tablet. Take 1 (one) tab (tablet) by mouth at
bedtime for dementia. 2100 (9:00 p.m.). Start
03/21/16."

The care plan for Resident # 3 dated 06/28/2016
documented, "(Resident # 3) has impaired
cognitive function, he is moderately impaired r/t
related to his cognitive abilities for daily decision
making." Under "Interventions" it documented,
"Administer medications as ordered."

Resident # 3's MAR (medication administration
record) dated June 2016 was reviewed. The
MAR documented,
- "Donepezil 5 MG (milligram) tablet. Take 1
  (one) tab (tablet) by mouth at bedtime for
dementia." Further review of the MAR revealed a
blank on 6/12/16 at 2100 (9:00 p.m.).

Resident # 3's MAR (medication administration
record) dated July 2016 was reviewed. The MAR
documented,
- "Donepezil 5 MG (milligram) tablet. Take 1
  (one) tab (tablet) by mouth at bedtime for
dementia." Further review of the MAR revealed a
blank on 7/12/16 and 7/31/16 at 2100(9:00 p.m.).

On 8/17/16 at 1:05 p.m. an interview was
conducted with LPN (licensed practical nurse) #
5. When asked about the procedure for
documenting the administration of medications on
the MAR, LPN # 5 stated, "Document on the MAR
after the medications are given by putting my
initials on the corresponding date. If the meds
(medications) are refused, circle my initials and
document on the back of the MAR the date, time,
why the meds were refused and physician
F 282  Continued From page 48 notification. " When asked what blanks on the MAR meant, LPN # 5 stated, "Blanks on the dates of the MAR indicates it wasn't done." After reviewing the blanks on Resident #3's MARs dated June and July 2016 for the administration of Donepezil on 6/12/16, 7/12/16 and 7/31/16, LPN # 5 stated, "I can't say it was given."

On 8/17/16 at 1:15 p.m. an interview was conducted with LPN # 6, unit manager. When asked about blanks on the MAR, LPN # 6 stated, "Blanks on the dates of the MAR indicates it wasn't given." After reviewing the blanks on Resident #3's MARs dated June and July 2016 for the administration of Donepezil on 6/12/16, 7/12/16 and 7/31/16, LPN # 6 stated, "I can't say it was given."

On 8/17/16 at 6:20 p.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing following the care plan and the administration of medications. ASM # 2 stated, "If the care plan states to give a medication and you don't give it, it's not following the plan of care."

The facility's policy "Using the Care Plan" documented, "The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident."

On 8/17/16 at 5:20 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above findings.

No further information was presented prior to exit.
**F 282** Continued From page 49

References:

1. Used to treat dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and may cause changes in mood and personality) in people who have Alzheimer's disease (AD; a brain disease that slowly destroys the memory and the ability to think, learn, communicate and handle daily activities). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697032.html.

2. An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostate.html.

3. Not enough thyroid hormone to meet your body's needs. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html.

4. A blood disorder. This information was obtained from the website: https://medlineplus.gov/blooddisorders.html.

3. The facility staff failed to follow Resident # 14's care plan for the administration of Insulin, Humulin (2), Polyethylene Glycol (5), Metoprolol (6), and Lantus (7).

Resident # 14 was admitted to the facility on 10/30/09 with a readmission on 9/9/15 with diagnoses that included but not limited to:
cerebral vascular accident, (5), diabetes mellitus (6), hypertension (7), dysphagia (8), benign prostatic hyperplasia (9), low iron, deep vein thrombosis (10) and aortic aneurysm (11).

The most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/6/16 coded Resident # 14 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for daily decision making. Resident # 14 was coded as being independent with activities of daily living and requiring extensive assistance of one staff member for bathing.

The POS (Physician Order Sheet) dated 08/01/16 through 08/31/16 for resident # 14 documented: "Humulin. Inject subcutaneously before meals and at bedtime per sliding scale: if blood sugar 61-150=0 (zero) units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, 401-450=12 units, 451-500=14 units for DM (diabetes mellitus). Start 01/10/16. 0630 (6:30 a.m.), 1130 (11:30 a.m.), 1630 (4:30 p.m.) and 2000 (8:00 p.m.)."

"Lantus. Inject 30 (thirty) units subcutaneously at bedtime. 2100 (9:00 p.m.) Start 09/26/15."

"Polyethylene Glycol. Give 17 GRMS (grams) in liquid by mouth every day for constipation. 0800 (8:00 a.m.) Start 09/07/15."

"Metoprolol. 25 MG. Take 1 (one) tab twice daily for hypertension. 0800 and 1600 (4:00 p.m.) Start 09/07/15."

"Humulin. Inject 4 units subcutaneously three times daily before meals for DM (diabetes mellitus). 0730 (7:30 a.m.), 1130 (11:30 a.m.), 1630 (4:30 p.m.) Start 09/26/15."
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 282</td>
<td></td>
<td>Continued From page 51 The MAR (medication administration record) dated June 2016 for Resident # 14 documented the above physician orders. Review of the June 2016 MAR failed to evidence documentation of the fasting blood sugar, the amount of insulin and the site of administration of Humulin sliding scale insulin on 6/8/16 at 11:30 a.m. and 6/21/16 at 8:00 p.m. On 6/12/16 at 4:30 p.m. the fasting blood sugar documented was 277. According to the sliding scale Resident # 14 should have received six units of insulin, however the MAR failed to evidence documentation of the amount of insulin and the site of administration of Humulin insulin. Further review of the MAR failed to evidence documentation of the administration of Humulin 4 units on 6/8/16 and 6/17/16 at 11:30 a.m. and Polyesylene Glycol on 6/17/16 and 6/30/16 at 8:00 a.m. The June 2016 &quot;Nurse's Notes&quot; for Resident # 14 was reviewed. The &quot;Nurse's Notes&quot; failed to evidence documentation of Resident # 14's fasting blood sugar, the amount of insulin or the site of administration for 6/8/16 at 11:30 a.m. and 6/21/16 at 8:00 p.m. Further review of the June 2016 &quot;Nurse's Notes&quot; failed to evidence documentation of the amount of insulin and the site of administration of Humulin insulin on 6/12/16 at 4:30 p.m. The MAR (medication administration record) dated July 2016 for Resident # 14 documented the above physician orders. Review of the July 2016 MAR failed to evidence documentation of the fasting blood sugar, the amount of insulin and the site of administration of Humulin sliding scale insulin on 7/27/16 at 8:00 p.m. Further review of the MAR failed to evidence documentation of the administration of Lantus on 7/27/16 at 8:00 p.m.</td>
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<td>Humulin 4 units on 7/27/16 at 4:30 p.m., Polyethylene Glycol on 7/7/16 at 8:00 a.m., and Metoprolol on 7/19/16 and 7/25/16 at 4:00 p.m.</td>
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<td>The July 2016 &quot;Nurse's Notes&quot; for Resident # 14 was reviewed. The &quot;Nurse's Notes&quot; failed to evidence documentation of Resident # 14's fasting blood sugar, the amount of insulin or the site of administration for Humulin sliding scale insulin 7/27/16 at 8:00 p.m.</td>
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<td>The care plan for Resident # 14 documented, &quot;Focus: Resident at risk for altered bowel regime r/t (relater to) limited mobility. Date initiated 6/16/2015.&quot; Under &quot;Interventions&quot; it documented, &quot;Administer bowel medication / laxative per MD (medical doctor) orders.&quot; &quot;Focus. Resident has hypertension (HTN). Date initiated 6/17/2014.&quot; Under &quot;Interventions&quot; it documented, &quot;Give hypertensive medications as ordered.&quot; &quot;Focus. The resident has diabetes mellitus.&quot; Under &quot;Interventions&quot; it documented, &quot;Diabetes medication as ordered by doctor. Date initiated 06/16/2015.&quot;</td>
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|       | On 8/17/16 at 1:05 p.m. an interview was conducted with LPN (licensed practical nurse) # 5. When asked about the procedure for documenting the administration of medications on the MAR, LPN # 5 stated, "Document on the MAR after the medications are given by putting my initials on the corresponding date. If the meds (medications) are refused, circle my initials and document on the back of the MAR the date, time, why the meds were refused and physician notification." When asked about blanks on the MAR, LPN # 5 stated, "Blanks on the dates of the MAR indicates it wasn't done." After reviewing
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<td>F 282</td>
<td>Continued From page 53 the blanks on Resident #14's MARs dated June and July 2016 for the administration of Humulin sliding scale insulin, Humulin 4 units, Polyethylene Glycol, Metoprolol, and Lantus LPN # 5 stated, &quot;I can't say it was given.&quot; On 8/17/16 at 1:15 p.m. an interview was conducted with LPN # 1, unit manager. When asked about blanks on the MAR, LPN # 1 stated, &quot;Blanks on the dates of the MAR indicates it wasn't given.&quot; After reviewing the blanks on Resident #14's MARs dated June and July 2016 for the administration of Humulin sliding scale insulin, Humulin 4 units, Polyethylene Glycol, Metoprolol, and Lantus, LPN #1 stated, &quot;I can't say it was given.&quot; On 8/17/16 at 5:20 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above findings. No further information was presented prior to exit. References: (2) Insulin is used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the website: <a href="https://medlineplus.gov/druginfo/meds/a697021.html">https://medlineplus.gov/druginfo/meds/a697021.html</a>. (5) Used to treat occasional constipation. This information was obtained from the website: <a href="https://medlineplus.gov/druginfo/meds/a603032.html">https://medlineplus.gov/druginfo/meds/a603032.html</a>.</td>
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F 282 Continued From page 54

(6) Used alone or in combination with other medications to treat high blood pressure. This information was obtained from the website: <https://medlineplus.gov/druginfo/meds/a682864.html>.

(7) Lantus (Insulin glargine). Used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a600027.html.

(8) When blood flow to your brain stops. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/stroke.html.

(9) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(10) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(11) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.
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(12) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostate.html.

(13) A condition that occurs when a blood clot forms in a vein deep inside a part of the body. It mainly affects the large veins in the lower leg and thigh, but can occur in other deep veins such as in the arms and pelvis. This information was obtained from the website: https://medlineplus.gov/ency/article/000156.htm.

(14) A bulge or "ballooning" in the wall of an artery. Arteries are blood vessels that carry oxygen-rich blood from the heart to other parts of the body. If an aneurysm grows large, it can burst and cause dangerous bleeding or even death. This information was obtained from the website: https://medlineplus.gov/aorticaneurysm.html.

4. The facility staff failed to follow Resident #15's care plan initiated on 7/16/14 and revised on 7/12/16 to obtain laboratory specimens as ordered by the physician.

Resident #6 was admitted to the facility on 12/29/12 and readmitted on 8/13/15 with diagnoses that included but were not limited to: urinary tract infection, diabetes, high blood pressure, dementia, kidney disease and elevated cholesterol.

The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 6/29/16 coded that the resident
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<td>as having an 11 out 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired cognitively to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.</td>
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<td>Review of the physician's orders dated and signed on 7/29/16 documented, &quot;HGB (hemoglobin) A1C (1) EVERY THREE MONTHS (JAN (January)/APRIL/JULY/OCT (October)).&quot;</td>
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<td>Review of the Resident #15's physician standing orders, not dated, documented, &quot;Labs (laboratory tests): If receiving medication, please follow the parameters for lab monitoring as established below: BMP (basic metabolic panel (2)), antihypertensive/ ACEI (angiotensin-converting enzyme (ACE) inhibitors (3)) / ARB (angiotensin II receptor blockers (4)) / diuretics (5)...upon admission and....every 6 months.&quot;</td>
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<td>Review of the physician's orders dated and signed 7/29/16, documented, &quot;EUROSEMIDE (6) 40MG (milligrams) TABLET FOR&gt; LASIX (7) TAKE 1 TAB (tablet) BY MOUTH EVERY MORNING FOR GENERAL EDEMA.&quot;</td>
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<td>Review of the care plan initiated on 7/16/14 and revised on 7/12/16, documented, &quot;Focus. Resident at risk for altered cardiac output due to dx (diagnoses), of HTN (hypertension), and HLD (hyperlipids). Interventions. Labs (laboratory tests) per orders. Focus. Resident at risk for hypo/hyperglycemia (high or low blood sugar). Resident with dx of DM (Diabetes Mellitus). Interventions. Labs per orders.&quot;</td>
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<td>Review of Resident #15's laboratory results did</td>
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not evidence documentation for the January 2016, BMP results or the July 2016, BMP and HBG A1C results.

On 8/17/16 at 5:49 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

An interview was conducted on 8/18/16 at 8:02 a.m. with LPN Licensed practical nurse) #3 and CNA (certified nursing assistant and unit secretary) #1. LPN #3 stated they could not locate the January and July BMP results or the July HGB A1C results. LPN #3 stated, "She (Resident #15) had a HGB A1C in June and the tech (technician) should have called him (the doctor) to see if he wanted another one. It should have been done." LPN #3 then stated, "We have developed a plan to correct this. We are doing a lab audit now." CNA #1 stated, "I keep all the yellow lab slips in a notebook and when the results come back I match it to the yellow slip." CNA #1 stated that if the result was not received she would follow up with the laboratory company.

No further information was provided prior to exit.

(1) The A1C test is a blood test that provides information about a person's average levels of blood glucose, also called blood sugar, over the past 3 months. The A1C test is sometimes called the hemoglobin A1c, Hba1c, or glycohemoglobin test. The A1C test is the primary test used for diabetes management and diabetes research. This information was obtained from:
https://www.niddk.nih.gov/health-information/diab
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<td>etes/diagnosis-diabetes-prediabetes/a1c-test</td>
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<td>(2) BMP -- A metabolic panel is a group of tests that measures different chemicals in the blood. These tests are usually done on the fluid (plasma) part of blood. The tests provide information about your body's chemical balance and metabolism. They can give doctors information about your muscles (including the heart), bones, and organs, such as the kidneys and liver. This information was obtained from: <a href="https://medlineplus.gov/metabolicpanel.html">https://medlineplus.gov/metabolicpanel.html</a></td>
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<td>(3) ACEI -- The angiotensin-converting enzyme (ACE) inhibitors are a widely used class of antihypertensive medications that act by blocking the conversion of angiotensin I to angiotensin II, thus inhibiting an intermediate step in the renin-angiotensin pathway. The ACE inhibitors are rare causes of clinically apparent liver injury. This information was obtained from: <a href="http://livertox.nih.gov/Angiotensin-Converting_Enzyme_Inhibitors.htm">http://livertox.nih.gov/Angiotensin-Converting_Enzyme_Inhibitors.htm</a></td>
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<td>(4) ARB -- The angiotensin II receptor blockers (ARBs) represent a newer class of antihypertensive agents. Their mechanism of action differs from that of the angiotensin-converting enzyme (ACE) inhibitors, which also affect the renin-angiotensin system. This information was obtained from: <a href="http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1200815/">http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1200815/</a></td>
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<td>(5) Diuretics -- Diuretics constitute a large family of medications that increase urine flow and induce urinary sodium loss and are widely used for therapy of hypertension, congestive heart failure, and edematous states. This information was obtained from: <a href="http://livertox.nih.gov/Diuretics.htm">http://livertox.nih.gov/Diuretics.htm</a></td>
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<td>(6) Furosemide -- Furosemide is a potent diuretic which, if given in excessive amounts, can lead to</td>
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<td>a profound diuresis with water and electrolyte depletion. This information was obtained from: <a href="https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=59b21dbe-30a0-405b-b39e-c19cea7ad9d6">https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=59b21dbe-30a0-405b-b39e-c19cea7ad9d6</a> (7) Lasix – LASIX® (furosemide) is a potent diuretic which, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte depletion. This information was obtained from: <a href="https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=EADFE464-720B-4DCD-A0D8-45DBA706BD33">https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=EADFE464-720B-4DCD-A0D8-45DBA706BD33</a></td>
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<td>F 309</td>
<td>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</td>
<td>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</td>
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This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and services to maintain the highest level of well-being for six of 25 residents, Resident #s 7, 3, 14, 4, 6 and 8.

1 a. The facility staff failed to administer medications to Resident #7 as ordered for four different medications on 10 different occasions.

1. We are unable to document 02 sats not previously documented as ordered on 7/7 to 7/8 for resident #7. The MD was notified on 9/2/16 of the O2 sats obtained during that period of time, ranging from 94% to 96% on room air.

We are unable to document previous medication administration identified as blanks on the MAR/TAR for residents #7, #3, and #14.

Resident #4 had a completed pain assessment documented on 7/20/16. We are unable to document an in depth pain assessment for 7/16, 7/23, and 7/24. An updated pain assessment was completed on 9/2/16.
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1 b. The facility staff failed to follow the physician's orders for Resident #7 and obtain O2 (oxygen) saturation levels every four hours as ordered on 7/17/16 and to report the results to the physician on 7/18/16.

2. The facility staff failed to follow the physician's order for the administration Resident #3's medications of Donepezil (1) and Atorvastatin (15).

3. The facility staff failed to follow the physician's order for the administration Resident #14's medications of Humulin (2), Polyethylene Glycol (5), Metoprolol (6), Lantus (7) and Clopidogrel (16).

4. The facility staff failed to complete an in depth pain assessment (including quality descriptors such as: intensity, quality, duration and pattern) prior to administering as needed pain medication to Resident #4 on 7/16/16, 7/23/16 and 7/24/16.

5. Facility staff failed to obtain physician ordered weights every three days for Resident #6 on seven occasions out 24 opportunities from June 2016 to August 2016.

6. Facility staff failed to apply palm guards to Resident #8's hands as ordered by the physician.

The findings include:

1 a. The facility staff failed to administer medications to Resident #7 as ordered for four different medications on 10 different occasions.

---

Resident #6's care plan has been revised as of 9/6/16 to reflect weights every 3 days. We are unable to document any previously missed weights. As of 8/18/16 the bilateral soft palm guards for resident #8 have been applied. Skin checks were done and no pressure or skin irritation noted. Resident is tolerating the palm guards with no pain or discomfort noted. Pain and skin assessments were updated on 9/6/16. Physician's order has been obtained for bilateral soft palm guards to be applied when up and out of bed, every shift skin checks for skin integrity.

2. A 100% audit of all physician orders received from 8/1/16 will be completed by the DON, ADON, UMs, or designee. This audit will identify any order for MD notification to ensure notification was completed as ordered, and documented.

A 100% audit of MAR's/TAR's will be done initially to ensure documentation is present. Audits to be done by the Unit Manager, Supervisor, or designee. Then MAR's/TAR's will be audited daily by the Supervisors to ensure documentation is complete. Any nurse identified as failing to complete their documentation will be called back in to complete any missing documentation.
F 309 Continued From page 61

Resident #7, a 70 year old female, was admitted to the facility on 5/3/12, with a readmission on 1/19/16, with diagnoses that included, but were not limited to: metabolic encephalopathy [1] (a neurological disorder caused by systemic illness, such as diabetes, liver disease, renal failure and heart failure), hyperkalemia (elevated potassium levels in blood), malignant neoplasm of the sigmoid colon (cancer of part of the colon that leads to the rectum), vascular dementia and schizophrenia.

Resident #7's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 6/5/16. Resident #7 was coded on the Brief Interview of Mental Status as having a score of 15 out of a possible 15, indicating she is cognitively intact.

A review of Resident #7's physician order summary signed and dated by the physician on 8/18/16 revealed, in part, the following medication orders:

"Olopatadine HCL [2] 0.1 % (percent) drops. Instill 1 (one) drop into each eye twice daily. Allergies. Start date 1/27/16.”

"Sea Soft [3] 0.65% spray. 1 spray into each nostril twice daily. Start date 1/27/16.”

"Miz-Aid [4] 80 mg (milligrams) 1 tab (tablet) by mouth four times daily. Rx (diagnosis) reflux. Start date 1/27/16.”

"Aspirin [5] EC (enteric coated) 81 mg tablet. 1 tab by mouth every day. Start date 6/27/16.”

An audit of all residents receiving PRN pain medication will be done to include documentation of in depth pair assessment and documentation of effectiveness of pain medication administered. This audit will be done by DON, ADON, UMs, or designee.

A 100% audit of all residents with physician’s orders for weights will be completed by MDS Coordinators or designee to ensure this order is incorporated into the care plan.

An audit of 100% of residents with order for splints will be done by the DON, ADON, UM, or designee. Audits to include whether splints ordered are being applied and removed as ordered and documentation by nurses is accurate.

An audit of 100% of residents with sliding scale insulin orders will be done by the DON, ADON, UM or designee to ensure orders were followed with repeat finger sticks obtained and/or MD notification per order.

3. All new physician’s orders written will be reviewed by the Nursing Review team, during the SOC review meeting. Any order for physician notification will be documented on a tracking tool and followed up by the Unit Manager or designee to ensure notification occurs. The Weekend Supervisor or designee will implement review of all orders.
Continued From page 62

date a medication was given except for the following medications and dates where there were no initials indicating that the medication was administered:

"Olopatadine HCL (hydrochloride) 0.1% drops. Instill 1 (one) drop into both eyes twice daily." On 7/30/16 at 1700 (5:00 p.m.) there is no initial indicating administered.

"Sea Soft 0.65% spray for nasal spray. 1 spray into each nostril twice daily." On 7/21/16, 7/23/16, 7/24/16 and 7/31/16 at 0900 (9:00 a.m.) there are no initials indicating administered.

"Mi-acid 80 mg (milligrams) tab (tablet) chew. 1 tab by mouth four times daily." On 7/12/16 and 7/30/16 at 1700 (5:00 p.m.) and 2100 (9:00 p.m.) there are no initials indicating administered.

"Aspirin EC (enteric coated) 81 mg tab po (by mouth) qd (every day)." On 7/14/16 at 0900 (9:00 a.m.) there is no initial indicating administered.

A review of Resident #7's nursing notes did not reveal any documentation about medications not being administered.

On 8/17/16 at 12:15 p.m. an interview was conducted with LPN #13. LPN #13 was asked to describe the process of signning medications off on the MAR as administered. LPN #13 stated, "I double check each medication using the 5 (five) rights and sign by initials in the space for that medication. When I take the medication to the resident and they refuse it then I circle my initial for that medication and time and document that the resident refused either on the back of the MAR or in the nurse's notes." LPN #13 was asked what a blank box on the MAR indicated. LPN #13 stated, "If there was a blank spot I would assume that the medication was not given as received during weekend hours, document MD notification orders on the tracking tool and follow up on any notifications ordered during the weekend hours.

A pain assessment form will be implemented for documentation of in-depth pain assessment for each resident receiving a PRN pain medication. This form will include documentation of the effectiveness of PRN pain medication administered. All nurses will be educated on the use of this form. Education will be provided to all new hire RNs and LPNs during their new hire orientation process.

A list of all residents with physician's orders for weights will be developed and maintained by the Dietary Manager. Ordered weights will be listed on the resident's MAR/TAR with weights documented on the MAR/TAR. This list of ordered weights will be copied to the MDS Coordinators and included in the care plan process.

4. A 10% audit of all MD ordered notifications, as identified on the tracking tool will be done by the DON, ADON, UMs, or designee monthly times three months. Results of audits will be presented at the Quarterly QA Meeting.
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<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<td>F 309</td>
<td>Continued From page 63 ordered.</td>
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On 8/17/16 at 4:40 p.m. an interview was conducted with LPN (licensed practical nurse) #1, the north wing unit manager. LPN #1 was asked what the nurses should document when administering a medication. LPN #1 stated that the nursing staff should sign off on the MAR when they pull the medication from the cart, if the resident refuses the medication then the nurse should circle the initial entry on the MAR and document that the resident had refused. LPN #1 was asked what a blank spot on the MAR indicated. LPN #1 stated, "If it is not documented, it was not done." LPN #1 was shown the July MAR for Resident #7 and asked what the blank areas on the MAR for the four medications described above indicated. LPN #1 stated, "The medications were not administered."

On 8/17/16 at 3:20 p.m. an interview was conducted with LPN #3. LPN #3 was asked what blank spots on the MAR indicated. LPN #3 stated, "If the box is not initialed then the medication was not given. Nursing staff should review the MAR at the end of their shift to be sure there are no blank spots.

A review of the facility policy titled, "General Dose Preparation and Medication Administration" revealed, in part, the following documentation; "6. After medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information (e.g., when medications re opened, when medications are given, injection site of a medication, if medications are refused, PRN (as

A 5% audit of MAR's/TAR's will be done monthly by the DON, ADON, UMs, or designee for two months to ensure documentation is complete.

An audit of 50% of resident's receiving pain medication with appropriate documentation will be done by Supervisors or designee times one month, then 10% times two months times two months.

25% of all residents with physician's orders for weights will be audited by the Dietary Manager or designee times one month, then 10% audited times one month.

A list of all residents with orders for splints will be developed and maintained by the MDS Coordinators. 10% of the residents on this list will be audited by the Restorative Nurse Aid or designee monthly times three months.

10% of residents with sliding scale insulin orders will be audited by DON, ADON, UM or designee monthly times three months.

Results of audits will be presented to the Quarterly Quality Assurance Committee Meeting.

5. Corrective action will be completed October 1, 2016.
F 309 Continued From page 64

needed) medications, application sight (sic)) on appropriate forms."

An end of day meeting was conducted with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above findings at this time. A policy was requested regarding following physician orders.

On 8/18/16 at 7:25 a.m., ASM (administrative staff member) #2 (the director of nursing) stated the facility did not have a policy regarding following physician orders.

No further information was provided prior to the end of the survey process.

[1] This information was obtained from the following website:
http://www.ncbi.nlm.nih.gov/books/NBK20383/

[2] Used for the treatment of the signs and symptoms of allergic conjunctivitis. This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=e3a0ef7f-292e-4156-924c-6d8121b69990

[3] Used to treat dryness inside the nasal passages. This information was obtained from the following website:

[4] An antacid used to treat heartburn, sour stomach and gas. This information was obtained from the following website:
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<th>F 309</th>
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<td></td>
<td>m?setid=5aec9caa-0fa1-408d-95db-4d2bd33fc9f2</td>
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</table>

[5] Used to lower the risk for heart attack by inhibiting formation of blood clots in the vessels. This information was obtained from the following website:
http://www.mayoclinic.org/diseases-conditions/heart-disease/in-depth/daily-aspirin-therapy/art-20046797

1 b. The facility staff failed to follow the physician orders for Resident #7 and obtain O2 (oxygen) saturation levels every four hours as ordered on 7/7/16 and to report the results to the physician on 7/8/16.

Resident #7, a 70 year old female, was admitted to the facility on 5/3/12, with a readmission on 1/19/16, with diagnoses that included, but were not limited to; metabolic encephalopathy [1] (a neurological disorder caused by systemic illness, such as diabetes, liver disease, renal failure and heart failure), hyperkalemia (elevated potassium levels in blood), malignant neoplasm of the sigmoid colon (cancer of part of the colon that leads to the rectum), vascular dementia and schizophrenia.

Resident #7's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 6/5/16. Resident #7 was coded on the Brief Interview of Mental Status as having a score of 15 out of a possible 15, indicating she is cognitively intact.

A review of Resident #7's clinical record revealed, in part, a physician order dated 7/7/16, signed by the physician on 7/9/16, that documented, in part,
Continued from page 66

the following: "O2 (oxygen) at 2 (two) liters via nasal cannula. (Check mark) O2 sats (saturation) Q (every) 4 (four) hrs (hours). Report to (name of doctor) in AM (morning) - 7/8/16."

A review of Resident #7's MAR (medication administration record) dated July 2016 revealed, in part, the following entry: "(sign for check) O2 sats Q4 hrs 7/7/16. Frequency: 4 PM, 8 PM, 12 MN (midnight), 7/8/16 at 4 AM, 8 AM, 12 noon." O2 sats were documented for 4 PM, 8 PM and 12 MN. There were no O2 sats documented for 7/8/16 4 AM and 8 AM.

A review of Resident #7's nursing notes did not reveal any documentation of the O2 sats for 7/8/16 at 4 AM and 8 AM.

On 8/17/16 at 5:20 p.m. an end of day meeting was conducted with ASM #1, the administrator and ASM #2, the director of nursing. The administrative staff were made aware of the above findings. ASM #1 and ASM #2 were asked to provide evidence that the physician had been notified of the O2 sats obtained on Resident #7 between 7/7/16 at 4:00 p.m. and 7/8/16 at 8:00 a.m. A policy regarding notifications to the physician was requested at this time.

An interview was conducted on 8/18/16 at 11:50 a.m. with LPN (licensed practical nurse) #1, the unit manager. LPN #1 was asked to review the physician order for Resident #7 dated 7/7/16 and to indicate where the O2 sats for 7/8/16 at 4 AM and 8 AM were documented. LPN #1 reviewed the documentation Resident #7's clinical record and stated that they were not documented in the clinical record. LPN #1 was asked where the O2 sats should have been documented. LPN #1
F 309  Continued From page 67
stated that they should have been documented on the MAR. LPN #1 was asked if the MAR had blank spaces what did that indicate. LPN #1 stated, it meant it was not done.

An interview was conducted on 8/18/16 at 11:55 a.m. with LPN #12. LPN #12 was asked whether or not the O2 sats for Resident #7 had been completed as ordered, LPN #12 stated, "I would have documented the O2 sats on the MAR, I remember this and I'm sure we documented them." LPN #12 was asked to review the MAR, LPN #12 stated that the O2 sats were not documented. LPN #12 also reviewed the nursing notes and stated that the O2 sats were not documented.

ASM (administrative staff member) #2, the director of nursing, was made aware of these findings on 8/18/16 at approximately 12:15 p.m.

No further evidence was provided prior to the end of the survey process.

2. The facility staff failed to follow the physician's order for the administration of Resident #3's medications of Donepezil (1) and Atorvastatin (15).

Resident #3 was admitted to the facility on 6/19/15 with diagnoses that included but were not limited to: benign prostatic hyperplasia (2), low iron, hypothyroidism (3), and lymphocytopenia (4).

Resident #3's most recent comprehensive MDS (minimum data set), an annual assessment with
Continued From page 68

an ARD (assessment reference date) of 6/22/16, coded Resident # 3 as scoring a 10 (ten) on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 (ten) - being moderately impaired of cognition for making daily decisions. Resident # 3 was coded as being independent for activities of daily living.

The "Physician's Order Sheet" dated 08/01/16 through 08/31/16 and signed by the physician on 8/3/16 documented,
"Donepezil 5 MG (milligram) tablet. Take 1 (one) tab (tablet) by mouth at bedtime for dementia. 2100 (9:00 p.m.). Start 03/21/16."
"Atorvastatin. 10 MG. Take 1 tab by mouth every day at bedtime. Start 06/20/15."

Resident # 3's MAR (medication administration record) dated June 2016, was reviewed. The MAR documented,
"Donepezil 5 MG (milligram) tablet. Take 1 (one) tab (tablet) by mouth at bedtime for dementia."
"Atorvastatin. 10 MG. Take 1 tab by mouth every day at bedtime. Start 06/20/15."

Further review of the MAR revealed a blank on 6/12/16 at 2100 (8:00 p.m.), for the administration of Donepezil and Atorvastatin.

Resident # 3's MAR (medication administration record) dated July 2016, was reviewed. The MAR documented,
"Donepezil 5 MG (milligram) tablet. Take 1 (one) tab (tablet) by mouth at bedtime for dementia."
"Atorvastatin. 10 MG. Take 1 tab by mouth every day at bedtime. Start 06/20/15."

Further review of the MAR revealed a blank on 7/12/16 for the administration of Donepezil and
F 309 Continued From page 69
Atorvastatin on 7/19/16 at 9:00 p.m. and a blank on 7/31/16 at 2100 (9:00 p.m.) for the administration of Donepezil.

On 8/17/16 at 1:05 p.m. an interview was conducted with LPN (licensed practical nurse) # 5. When asked about the procedure for documenting the administration of medications on the MAR, LPN # 5 stated, "Document on the MAR after the medications are given by putting my initials on the corresponding date. If the meds (medications) are refused, circle my initials and document on the back of the MAR the date, time, why the meds were refused and physician notification." When asked what blanks on the MAR indicate, LPN # 5 stated, "Blanks on the dates of the MAR indicates it wasn't done." After reviewing the blanks on Resident #3's MARs dated June and July 2016 for the administration of Donepezil on 6/12/16, 7/12/16 and 7/31/16, LPN # 5 stated, "I can't say it was given."

On 8/17/16 at 1:15 p.m. an interview was conducted with LPN # 6, unit manager. When asked about blanks on the MAR, LPN # 6 stated, "Blanks on the dates of the MAR indicates it wasn't given." After reviewing the blanks on Resident #3's MARs dated June and July 2016 for the administration of Donepezil on 6/12/16, 7/12/16 and 7/31/16, LPN # 6 stated, "I can't say it was given."

According to Fundamentals of Nursing, Lippincott, Williams and Wilkins, 2007, page 165 reveals the following: "After administering a tablet or capsule, be sure to record: drug given, dose given, date and time of administration, signing out the drug on the patients medication record ..."
F 309 Continued From page 70

On 8/17/16 at 5:20 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above findings.

No further information was presented prior to exit.

References:

(1) Used to treat dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and may cause changes in mood and personality) in people who have Alzheimer’s disease (AD; a brain disease that slowly destroys the memory and the ability to think, learn, communicate and handle daily activities). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697032.html.

(2) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

(3) Not enough thyroid hormone to meet your body’s needs. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html.

(4) A blood disorder. This information was obtained from the website: https://medlineplus.gov/blooddisorders.html.

(15) Used together with diet, weight loss, and exercise to reduce the risk of heart attack and
<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>IO Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 71</td>
<td>stroke and to decrease the chance that heart surgery will be needed in people who have heart disease or who are at risk of developing heart disease, Atorvastatin is also used to decrease the amount of fatty substances such as low-density lipoprotein (LDL) cholesterol (&quot;bad cholesterol&quot;) and triglycerides in the blood and to increase the amount of high-density lipoprotein (HDL) cholesterol (&quot;good cholesterol&quot;) in the blood. This information was obtained from the website: <a href="https://medlineplus.gov/druginfo/meds/a600045.html">https://medlineplus.gov/druginfo/meds/a600045.html</a>.</td>
<td>F 309</td>
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<td>3.</td>
<td>The facility staff failed to follow the physician's order for the administration of Resident # 14's medications of Humulin (2), Polyethylene Glycol (5), Metoprolol (6), Lantus (7) and Clopidogrel (16).</td>
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<td>Resident # 14 was admitted to the facility on 10/30/09 with a readmission on 9/5/15 with diagnoses that included but not limited to: cerebral vascular accident, (5), diabetes mellitus (6), hypertension (7), dysphagia (8), benign prostatic hyperplasia (9), low iron, deep vein thrombosis (10) and aortic aneurysm (11).</td>
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<td>The most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/8/16 coded Resident # 14 as scoring a 14 on the brief interview for mental status (SIMS) of a score of 0 - 15, 14 being cognitively intact for daily decision making. Resident # 14 was coded as being independent with activities of daily living and requiring extensive assistance of one staff member for</td>
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**Brookside Rehab & Nursing Center**

**Street Address, City, State, Zip Code**

614 Hastings Lane

Warrenton, VA 20186

**Patient Identification Number:**

495267

**Date Survey Completed:**

08/18/2016
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bathing.

The POS (Physician Order Sheet) dated 08/01/16 through 08/31/16 for resident # 14 documented:
"Humulin. Inject subcutaneously before meals and at bedtime per sliding scale: If blood sugar 61-150=0 (zero) units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-3350=8 units, 351-400=10 units, 401-450=12 units, 451-500=14 units for DM (diabetes mellitus). Start 01/10/16. 0630 (6:30 a.m.), 1130 (11:30 a.m.), 1630 (4:30 p.m.) and 2000 (8:00 p.m.)."
"Lantus. Inject 30 (thirty) units subcutaneously at bedtime. 2100 (9:00 p.m.) Start 09/26/15."
"Polyethylene Glycol. Give 17 GRMS (grams) in liquid by mouth every day for constipation. 0800 (8:00 a.m.) Start 09/07/15."
"Metoprolol. 25 MG. Take 1 (one) tab twice daily for hypertension. 0800 and 1600 (4:00 p.m.) Start 09/07/15."
"Humulin. Inject 4 units subcutaneously three times daily before meals for DM (diabetes mellitus). 0730 (7:30 a.m.), 1130 (11:30 a.m.), 1630 (4:30 p.m.) Start 09/26/15."
"Clopidogrel. 75 MG. Take 1 tab by mouth every day at bedtime. Start 09/08/15."

The MAR (medication administration record) dated June 2016 for Resident # 14 documented:
"Humulin. Inject subcutaneously before meals and at bedtime per sliding scale: If blood sugar 61-150=0 (zero) units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-3350=8 units, 351-400=10 units, 401-450=12 units, 451-500=14 units for DM (diabetes mellitus). Start 01/10/16. 0630 (6:30 a.m.), 1130 (11:30 a.m.), 1630 (4:30 p.m.) and 2000 (8:00 p.m.)."
"Polyethylene Glycol. Give 17 GRMS (grams) in liquid by mouth every day for constipation. 0800 (8:00 a.m.) Start 09/07/15."

If continuation sheet Page 73 of 164
Continued From page 73 (8:00 a.m.) Start 09/07/15."
"Humulin. Inject 4 units subcutaneously three times daily before meals for DM. 0730 (7:30 a.m.), 1130 (11:30 a.m.), 1630 (4:30 p.m.) Start 09/26/15."

Review of the June 2016 MAR failed to evidence documentation of the fasting blood sugar, the amount of insulin and the site of administration of Humulin sliding scale insulin on 6/8/16 at 11:30 a.m. and 6/21/16 at 8:00 p.m. On 6/12/16 at 4:30 p.m. the fasting blood sugar documented was 277. According to the sliding scale Resident # 14 should have received six units of insulin, however the MAR failed to evidence documentation of the amount of insulin and the site of administration of Humulin insulin. Further review of the MAR failed to evidence documentation of the administration of Humulin 4 units on 6/8/16 and 6/17/16 at 11:30 a.m. and Polyethylene Glycol on 6/17/16 and 6/30/16 at 8:00 a.m.

The June 2016 "Nurse's Notes" for Resident # 14 was reviewed. The "Nurse's Notes" failed to evidence documentation of Resident # 14's fasting blood sugar, the amount of insulin or the site of administration for 6/8/16 at 11:30 a.m. and 6/21/16 at 8:00 p.m. Further review of the June 2016 "Nurse's Notes" failed to evidence documentation of the amount of insulin and the site of administration of Humulin insulin on 6/12/16 at 4:30 p.m.

The MAR (medication administration record) dated July 2016 for Resident # 14 documented: "Humulin. Inject subcutaneously before meals and at bedtime per sliding scale: If blood sugar 61-150=0 (zero) units, 151-200=2 units,
<table>
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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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| F 309         | Continued From page 74  
201-250=4 units, 251-300=6 units, 301-3350=8 units, 351-400=10 units, 401-450=12 units,  
451-500=14 units for DM (diabetes mellitus),  
Start 01/10/16. 0630 (6:30 a.m.), 1130 (11:30  
am.), 1630 (4:30 p.m.) and 2000 (8:00 p.m.)."  
"Lantus. Inject 30 (thirty) units subcutaneously at  
bedtime. 2100 (9:00 p.m.) Start 09/26/15."  
"Polyethylene Glycol. Give 17 GRMS (grams) in  
liquid by mouth every day for constipation. 0800  
(8:00 a.m.) Start 09/07/15."  
"Metoprolol. 25 MG. Take 1 (one) lab twice daily  
for hypertension. 0800 and 1600 (4:00 p.m.)  
Start 09/07/15."  
"Humulin. Inject 4 units subcutaneously three  
times daily before meals for DM. 0730 (7:30  
am.), 1130 (11:30 a.m.), 1630 (4:30 p.m.) Start  
09/26/15."  
"Clopidogrel. 75 MG. Take 1 lab by mouth every  
day at bedtime. Start 09/08/15."  
Review of the July 2016 MAR failed to evidence  
documentation of the fasting blood sugar, the  
amount of insulin and the site of administration  
of Humulin sliding scale insulin on 7/27/16 at 8:00  
p.m. Further review of the MAR failed to  
documentation of the administration of  
Lantus on 7/27/16 at 9:00 p.m., Humulin 4 units  
on 7/27/16 at 4:30 p.m., Polyethylene Glycol on  
7/7/16 at 8:00 a.m., and Metoprolol on 7/19/16  
and 7/25/16 at 4:00 p.m.  
The July 2016 "Nurse's Notes" for Resident # 14  
was reviewed. The "Nurse's Notes" failed to  
documentation of Resident # 14's  
fasting blood sugar, the amount of insulin or the  
site of administration for Humulin sliding scale  
insulin 7/27/16 at 8:00 p.m.  
On 8/17/16 at 1:05 p.m. an interview was
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<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<td>F 309</td>
<td>Continued From page 75 conducted with LPN (licensed practical nurse) # 5. When asked about the procedure for documenting the administration of medications on the MAR, LPN # 5 stated, &quot;Document on the MAR after the medications are given by putting my initials on the corresponding date. If the meds (medications) are refused, circle my initials and document on the back of the MAR the date, time, why the meds were refused and physician notification.&quot; When asked about the blanks are the MAR, LPN # 5 stated, &quot;Blanks on the dates of the MAR indicates it wasn't done.&quot; After reviewing the blanks on Resident #14's MARs dated June and July 2016 for the administration of Humulin sliding scale insulin, Humulin 4 units of insulin, Polyethylene Glycol, Metoprolol, and Lantus LPN # 5 stated, &quot;I can't say it was given.&quot; On 8/17/16 at 1:15 p.m. an interview was conducted with LPN # 1, unit manager. When asked about the blanks are the MAR, LPN # 1 stated, &quot;Blanks on the dates of the MAR indicates it wasn't given.&quot; After reviewing the blanks on Resident #14's MARs dated June and July 2016 for the administration of Humulin sliding scale insulin, Humulin 4 units of insulin, Polyethylene Glycol, Metoprolol, and Lantus, LPN # 5 stated, &quot;I can't say it was given.&quot; On 8/17/16 at 5:20 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above findings. No further information was presented prior to exit. References: (2) Insulin is used to treat people with type 2 diabetes.</td>
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F 309 Continued From page 76 
diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the website: <https://medlineplus.gov/druginfo/meds/a697021.html>.

(5) Used to treat occasional constipation. This information was obtained from the website: <https://medlineplus.gov/druginfo/meds/a603032.html>.

(6) Used alone or in combination with other medications to treat high blood pressure. This information was obtained from the website: <https://medlineplus.gov/druginfo/meds/a682864.html>.

(7) Lantus (insulin glargine). Used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a600027.html.

(8) When blood flow to your brain stops. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/stroke.html.

(9) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website:
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<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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</table>

(10) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(11) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(12) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatetabph.html.

(13) A condition that occurs when a blood clot forms in a vein deep inside a part of the body. It mainly affects the large veins in the lower leg and thigh, but can occur in other deep veins such as in the arms and pelvis. This information was obtained from the website: https://medlineplus.gov/ency/article/000156.htm.

(14) A bulge or "ballooning" in the wall of an artery. Arteries are blood vessels that carry oxygen-rich blood from the heart to other parts of the body. If an aneurysm grows large, it can burst and cause dangerous bleeding or even death. This information was obtained from the website: https://medlineplus.gov/aorticaneurysm.html.

(16) Used alone or with aspirin to prevent serious or life-threatening problems with the heart and blood vessels in people who have had a stroke, heart attack, or severe chest pain. This includes people who have percutaneous coronary
Continued From page 78
intervention (PCI; angioplasty; a type of heart surgery) that may involve inserting coronary stents (metal tubes surgically placed in clogged blood vessels to improve blood flow) or who have coronary artery bypass grafting (CABG; a type of heart surgery). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601040.html.

4. The facility staff failed to complete an in depth pain assessment (including quality descriptors such as: intensity, quality, duration and pattern) prior to administering as needed pain medication to Resident #4 on 7/16/16, 7/23/16 and 7/24/16.

Resident #4 was admitted to the facility on 9/27/11. Resident #4’s diagnoses included but were not limited to: dementia (1), osteoarthritis (2) and gout (3). Resident #4’s most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 7/3/16, coded the resident’s cognition as severely impaired. Section J documented Resident #4 had not voiced any complaints of pain during the five day look back period.

Review of Resident #4’s clinical record revealed a physician’s order dated 7/16/16 that documented, “Tylenol (used to relieve mild to moderate pain) (4) 650 mg (milligrams) po (by mouth) q (every) 4 (hours) PRN (as needed) for discomfort x (times) 48 (hours) then notify md (medical doctor).” Resident #4’s July 2016 MAR (medication administration record) revealed the resident was administered Tylenol 650 mg on the following days:
### Statement of Deficiencies and Plan of Correction

#### Summary Statement of Deficiencies

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7/16/16 for a complaint of "I'm sick."
7/23/16 for a complaint of generalized pain.
7/24/16 for a complaint of generalized pain.

No nurses' notes dated 7/16/16, 7/23/16 or 7/24/16 were present in Resident #4's clinical record.

Resident #4's comprehensive care plan revised on 7/12/15 documented, "The resident has Arthritis/ She is at risk for pain...Interventions: Give analgesics as ordered by the physician. Monitor and document for side effects and effectiveness...Monitor/document/report to MD FRN s/sx (signs and symptoms) or complications related to arthritis: Joint pain, Joint stiffness, usually worse on wakening, Swelling, Decline in mobility, Decline in self care ability, Contracture formation/joint shape changes, Crepitus (creaking or clicking with joint movement), pain after exercise or weight bearing."

The nurse responsible for administering Tylenol to Resident #4 on 7/16/16 was not available for interview.

On 8/17/16 at 7:35 a.m., an interview was conducted with LPN (licensed practical nurse) #4 (the nurse responsible for administering Tylenol to Resident #4 on 7/24/16). LPN #4 was asked what should be done prior to administering as needed pain medication. LPN #4 stated she repositions the resident; the resident may need more blankets or pillows; the resident may need an overlay (on the mattress); sometimes she likes to give residents hot tea. LPN #4 was asked what her pain assessments consist of. LPN #4 stated she just goes in and assesses the resident. LPN #4 stated she would not
**Summary Statement of Deficiencies**

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- **Summary Statement of Deficiencies**
  - **(Each deficiency must be preceded by full regulatory or license identifying information)**

- **Providers Plan of Correction**
  - **(Each corrective action should be cross-referenced to the appropriate deficiency)**

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**Brookside Rehab & Nursing Center**

**Street Address, City, State, Zip Code**

614 Hastings Lane

Warrenton, VA 20186

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necessarily document her assessment for someone who was just receiving Tylenol. LPN #4 stated she would assess the cause of the pain and document any redness if noted. LPN #4 stated if she couldn't find the cause and none of her interventions helped then she would give Tylenol and recheck the pain.

On 8/17/16 at 8:26 a.m., an interview was conducted with LPN #1, unit manager. LPN #1 was asked what should be done prior to administering as needed pain medication. LPN #1 stated she would do an assessment; ask where the pain was located and ask the level of pain depending on the resident's cognition. LPN #1 stated she would attempt repositioning, play soft music, change the resident's environment, offer toileting or offer something to eat. LPN #1 was asked if pain assessments and non-pharmacological interventions should be documented when a resident is administered as needed pain medication. LPN #1 stated, "In the nurses' notes or the MAR. They are supposed to document." LPN #1 was asked the purpose of documenting pain assessments and non-pharmacological interventions. LPN #1 stated, "It's a regulation. You can't give pills for convenience. You have to make sure you are taking proper care of residents. You shouldn't be giving Tylenol to everyone. You have to have a reason. We need documentation. We can't get around that." LPN #1 was asked how the pain documentation was utilized by staff. LPN #1 stated pain assessments were used at the standards of care meetings conducted by staff. LPN #1 stated staff tries to problem solve and find out what's going on at the standards of care meetings. LPN #1 stated, "If I don't have documentation that's kinda null and void."
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Assessments are very important. That's nursing 101."

On 8/17/16 at 3:00 p.m., an interview was conducted with RN (registered nurse) #2 (the nurse responsible for administering Tylenol to Resident #4 on 7/23/16). RN #2 was asked what should be done prior to administering as needed pain medication. RN #2 stated, "Check allergies; ask (the resident) to rate the pain; go based on facial grimacing, behaviors; use the faces scale; try repositioning; ask what the problem is; see if you can address without pain medication; document their complaint; an hour later check to see if (the medication is) effective." RN #2 stated the information should be documented on skilled sheets (a form of nurses' notes) and the 24 hour report: RN #2 was asked the purpose of documenting this information. RN #2 stated, "To show you have used nursing interventions. Medication is the last resort. If we don't document, it doesn't show that we did it." RN #2 was asked if pain assessment documentation was used at the facility to plan residents' future pain management. RN #2 stated, "I think so. Yes." RN #2 stated staff has to anticipate residents' needs and pain assessments are used for residents' plan of care. RN #2 was asked to provide documentation regarding Resident #4's pain assessment on 7/23/16 when she administered Tylenol to the resident. RN #2 stated Resident #4 rarely complained of pain but complained of pain that day. RN #2 stated she asked the resident what was wrong and gave the resident something to drink. RN #2 stated Resident #4 said she was achy so she gave her Tylenol. RN #2 stated she asked the resident how she was feeling and what her pain was. RN #2 was asked if she asked the resident how her...
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pain felt or the location of the pain. RN #2 stated she didn't recall if she asked Resident #4 where her pain was but she thought she did. RN #2 stated Resident #4 usually didn't complain of pain but was able to describe pain.

On 8/17/16 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Pain- Clinical Protocol" documented in part, "Assessment and Recognition: 1. The physician and staff will identify individuals who have pain or who are at risk for having pain. a. This includes a review of each person's known diagnoses and conditions that commonly cause or predispose to pain; for example, degenerative joint disease, rheumatoid arthritis, osteoporosis (with or without vertebral compression fractures), diabetic neuropathy, oral or dental pathology, and post-stroke syndromes. b. It also includes a review for any treatments that the resident currently is receiving for pain, including complementary (non-pharmacologic) treatments. 2. The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. 3. The staff and physician will identify the nature (characteristics such as location, intensity, frequency, pattern, etc.) and severity of pain. a. Staff will assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level. b. The staff will observe the resident (during rest and movement) for evidence of pain; for example, grimacing while being repositioned or having a
## Statement of Deficiencies and Plan of Correction

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<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
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wound dressing changed. 4. The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated; for example, wound care, ambulation, or repositioning. 5. The staff and physician will also evaluate how pain is affecting mood, activities of daily living, sleep, and the resident's quality of life, including complications such as gait disturbances, social isolation, and falls...Monitoring: 1. The staff will reassess the individual's pain and related consequences at regular intervals; at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. a. For example, review of frequency and intensity of pain, ability to perform activities of daily living (ADLs), sleep pattern, mood, behavior, and participation in activities...”

No further information was presented prior to exit.

Fundamentals of Nursing, 6th Edition, Potter and Perry, 2005, pages 1239-1287, "Nurses need to approach pain management systematically to understand a client's pain and to provide appropriate intervention....it is necessary to monitor pain on a consistent basis....Assessment of common characteristics of pain helps the nurse form an understanding of the type of pain, its pattern, and types of interventions that may bring relief....Onset and duration....Location....Intensity....Quality....Pain Pattern....Relief Measures....Contributing Symptoms....Pain therapy requires an individualized approach....Nurses administer and monitor interventions ordered by physicians for pain relief and independently use pain-relief measures that complement those prescribed by a physician....Effective communication of a client's
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assessment of pain and his or her response to intervention is facilitated by accurate and thorough documentation. This communication needs to transpire from nurse to nurse, shift to shift, and nurse to other health care providers. It is the professional responsibility of the nurse caring for the client to report what has been effective for managing the client's pain. The client is not responsible for ensuring that this information is accurately transmitted. A variety of tools such as a pain flow sheet or diary will help centralize the information about pain management.

Complaint deficiency

(1) "Dementia is not a specific disease. It is a descriptive term for a collection of symptoms that can be caused by a number of disorders that affect the brain. People with dementia have significantly impaired intellectual functioning that interferes with normal activities and relationships. They also lose their ability to solve problems and maintain emotional control, and they may experience personally changes and behavioral problems, such as agitation, delusions, and hallucinations..." This information was obtained from the website:
http://www.ninds.nih.gov/disorders/dementias/dementia.htm

(2) "Osteoarthritis is the most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine." This information was obtained from the website:
https://medlineplus.gov/osteoarthritis.html

(3) "Gout is a common, painful form of arthritis. It causes swollen, red, hot and stiff joints." This
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information was obtained from the website:
https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-
meta?v%3Aproject=medlineplus&v%3Asources=
medlineplus-bundle&query=gout&ga=1.2084459
06.1308579129.1468338746

(4) This information was obtained from the
website:
https://medlineplus.gov/druginfo/meds/a681004.h
ml

5. The facility staff failed to obtain physician
ordered weights every three days for Resident #6
on seven occasions out 24 opportunities from
June 2016 to August 2016.

Resident #6 was admitted to the facility on
12/29/12 and readmitted on 8/13/15 with
diagnoses that included but were not limited to:
urinary tract infection, diabetes, high blood
pressure, dementia, kidney disease and elevated
cholesterol.

The most recent MDS (minimum data set), an
annual assessment, with an ARD (assessment
reference date) of 6/29/16 coded that the resident
as having an 11 out 15 on the BIMS (brief
interview for mental status) indicating the resident
was moderately impaired cognitively to make
daily decisions. The resident was coded as
requiring assistance from staff for all activities of
daily living.

Review of the physician’s orders signed and
dated on 7/27/16 documented, “09/17/15:
WEIGHT EVERY 3RD DAY.”

Review of the care plan initiated on 8/17/15 and
revised on 8/12/16 did not evidence
documentation that the resident was to be
**NAME OF PROVIDER OR SUPPLIER**

BROOKSIDE REHAB & NURSING CENTER  
614 HASTINGS LANE  
WARRENTON, VA 20186

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>F 309</td>
<td>Continued From page 86 weighed every three days. Review of the June, July and August 2016 MAR (medication administration record) documented, &quot;WEIGHT EVERY 3RD DAY.&quot; Review of the June 2016 MAR did not evidence documentation that Resident #6 was weighed on 8/10/16, 6/13/16, 6/25/16 or 6/28/16 as ordered. Review of the July 2016 MAR did not evidence documented that the resident was weighed on 7/10/16 as ordered. Review of the August 2016 MAR did not evidence documentation that the resident was weighed on 8/12/16 or 8/15/16 as ordered. An interview was conducted on 8/17/16 at 3:45 p.m. with LPN (licensed practical nurse) #3. When asked who obtained the resident's weights when they were ordered every three day, LPN #3 stated that the nursing staff obtained the weights except on Tuesday when an aide obtained the weights. When asked where the weights would be documented, LPN #3 stated that they would be documented on the treatment administration record. (*Note the weights for Resident #6, were noted to be documented on the MAR not the TAR [treatment administration record]). On 8/17/16 at 5:49 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. In &quot;Fundamentals of Nursing&quot; 6th edition, 2005;</td>
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Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419 "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

6. Facility staff failed to apply palm guards to Resident #8's hands as ordered by the physician.

Resident #8 was admitted to the facility on 1/25/13 and was readmitted on 3/23/13 with diagnoses that included but were not limited to: Alzheimer's disease, irregular heartbeat, elevated cholesterol and depression.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 6/5/16 coded the resident as rarely being understood and rarely understands. The resident was coded as requiring assistance from staff for all activities of daily living. The resident was assessed as having impaired range of motion in her arms and legs. In Section O, Special Treatments, Procedures, and Programs under "Technique C. Splint or brace assistance" was marked "0" number of days the treatment was performed.

An observation was made of Resident #8 on 8/16/16 at 1:55 p.m. The resident was lying in the bed, her eyes were closed. She did not have palm guards on her hands.

An observation was made of Resident #8 on 8/16/16 at 2:10 p.m. The resident was up in a geri chair, her eyes were open. Her hands were
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| F 309        | Continued From page 68 resting in her lap. Her fingers were contracted towards the palms with the right finger tips touching the palm. There were no palm guards on. On observation was made on 8/16/16 at 4:50 p.m. The resident was in bed with her eyes closed she did not have palm guards on her hands. An observation was made on 8/17/16 at 7:36 a.m. Resident #8 was lying in bed with the head of bed elevated, her eyes were closed. There were no palm guards on at that time. An observation was made on 8/17/16 at 11:22 a.m. The resident was up in a geri chair in the day room. There were no palm guards on her hands. An observation was made on 8/17/16 at 12:50 p.m. The resident was up in a geri chair in the dining room. There were no palm guards on her hands. Review of the physician's orders signed and dated on 8/1/16 documented, "02/08/16: APPLY BIL (bilateral) HAND SOFT GUARDS AND REMOVE EVERY 2 HOURS TO CHECK SKIN INTEGRITY."
<p>|              | Review of the resident's August 2016 treatment administration record documented, &quot;APPLY BIL HAND SOFT PALM GUARDS AND REMOVE EVERY TWO HOURS TO CHECK SKIN INTEGRITY.&quot; On each day of observation 8/16 and 8/17/16, for each shift the staff documented that the soft hand guards were on Resident #8. |</p>
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|       | Review of the care plan initiated on 2/19/15 and reviewed on 6/9/16 documented, "ADL's (activities of daily living) -- Resident is total dependent for her ADL's...she has hand palm guard for contracture management of her right hand. Interventions. apply palm guard to right hand for contracture management remove q (every) 2hr to check skin integrity as she will allow/tolerate."

Review of Resident #8's nurses notes from 4/25/16 to 8/16/16. There was no evidence documentation that the palm guards were on the resident's hands. On 8/15/16 at 10:30 a.m. the nurse's notes documented "BUE (both upper extremities)/BUE (both lower extremities) contractures."

Review of the monthly summary dated 8/8/16 documented, "O Special Treatments. Splint/brace assistance."

On 8/17/16 at 12:20 p.m. an interview was conducted with LPN (licensed practical nurse) #6, the nurse caring for the resident. When asked if the resident had palm guards, LPN #6 stated, "We haven't used the splint in a long time. It's excruciating for her to put the soft palm guard on. We generally put a wash cloth in her hands. We should get that order d/c'd (discontinued)." When asked to review the resident's treatment administration record for the palm guards and then asked if the documentation was accurate, LPN #6 stated, "No, we should be documenting the rolled washcloths as tolerated, it's just one of those things that get over looked." LPN #6 then stated, "Did you see a washcloth in her hand?"

When LPN #6 was asked to check for a washcloth in Resident #8's hands, LPN #6 stated,
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"Well she has some mobility she takes them out. I'll go give her some (washcloths) now." LPN #6 took two washcloths and rolled each one and placed one in each of Resident #8's hands.

On 8/17/16 at 4:10 p.m. an interview was conducted with RN (registered nurse) #1, the assistant director of nursing. When asked what staff do if they can not follow a physician's order for the palm guards, RN #1 stated, "They should talk to therapy and get therapy to discontinue it. Maybe try something different, something more comfortable for the resident." When asked if staff should document that a resident could not tolerate a treatment, RN #1 stated, "They should chart something." When asked if staff were to document that the palm guards were on when they were not, RN #1 stated, "It shouldn't be, no. Absolutely not. It should have been discontinued a long time ago. If the palm guard was not on they should have circled it on the MAR (medication administration record) and documented the reason on the back." When asked how staff knew about the resident's care, RN #1 stated that the care plan was used by the nurses, CNAs (certified nursing assistant), social services and activities. RN #1 stated, "We also have a CNA kardex." A request was made for Resident #8's CNA kardex. RN#1 stated she wanted to look for documentation regarding the palm guards and why they were not being used.

Review of the CNA kardex documented, "Special needs: 1. apply right hand palm and guard + remove Q (every) 2 HR to check skin integrity."

An interview was conducted with CNA #3, the assistant caring for the resident. CNA #3 was asked when they had stopped putting the palm
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guards on Resident #8. CNA #3 stated, "We didn't stop using them, every night I would take them off and wash her hands and then one day I came in and they weren't using it anymore." When asked if she knew of any problems with the palm guards, CNA #3 stated, "No." When asked if she had asked why the palm guards were not on the resident, CNA #3 stated she had not. When asked how she received report on the residents, CNA #3 stated, "We communicate between the CNAs at the change of shift. If I don't feel it's not enough information I will go to the nurse. We also have a care kardex." When asked how frequently she checked the kardex, CNA #3 stated, "I look at that at least once a week to make sure nothing has changed." CNA #3 was asked when the kardex is updated after a change in treatment is made for a resident, CNA #3 stated, "It would be changed that day because a copy is made and put on her door (closet) in her room." A request was made to look at Resident #8’s palms. CNA #3 took the washcloths from her palms. Resident #8’s hands were contracted with the right hand finger tips touching the palm and the left finger tips just above the palm. The right palm was reddened near the thumb, there were no open areas seen. CNA #3 replaced the washcloths. The resident who was awake at the time did not show any signs of discomfort when the washcloths were removed and reapplied.

An interview was conducted on 8/18/16 at 8:02 a.m. with RN #1, the assistant director of nursing. RN #1 stated that they could not locate the old therapy notes for Resident #8, that when the facility changed therapy companies the old company took all the residents' notes. RN #1 was asked if staff should not follow a doctor's order, RN #1 stated, "If it's a CNA she tells her nurse..."
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who should write a note that it's temporarily off or call the doctor to have it discontinued."

On 8/18/16 at 10:20 a.m. RN #1 stated she hadn't found anything (regarding documentation about the palm guards) and that she had not heard from the previous rehabilitation company.

On 8/17/16 at 5:45 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

An interview was conducted on 8/18/16 at 10:50 a.m. with OSM (other staff member) #4, the rehabilitation manager. When asked if he was familiar with Resident #8 he stated, "Other than they came for some palm guards yesterday afternoon." When asked if therapy would discontinue the palm guards if it was painful to apply, OSM #4 stated, "No, if they're indicated certainly." When asked what palm guards were used for, OSM #4 stated, "Skin protection."

No further information was provided prior to exit. 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

F 312

F 312

1. CNA #7 was educated immediately on proper documentation of meal intake for resident #12. The dietician was notified of resident #12's poor po intake and therapy screened the resident.

2. An initial audit of all residents identified as requiring verbal cueing or assistance with eating will be audited to identify that appropriate assistance is provided and that meal intake percentage is accurately documented. This audit will be done by the MDS Coordinators, Supervisors, or designee.
**NAME OF PROVIDER OR SUPPLIER**

BROOKSIDE REHAB & NURSING CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

614 HASTINGS LANE
WARRENTON, VA 20186

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**SUMMARY STATEMENT OF DEFICIENCIES**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

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was determined that the facility staff failed to provide feeding assistance for one of 25 residents in the survey sample, Resident #12.

Resident #12 was observed during three meal times (breakfast and lunch on 8/17/16 and breakfast on 8/18/16) not eating her food, the facility staff did not provide assistance with feeding to ensure that she ate her meals and obtained adequate nutrition.

The findings include:

Resident #12, a 91 year old female, was admitted to the facility on 8/26/10 with a readmission date of 9/24/10, with diagnoses that included, but were not limited to; dementia, depression, macular degeneration (disease of the eyes causing blindness), anxiety, anemia (a low red blood cell count), high blood pressure, atrial fibrillation (a dysrhythmia of the heart) and kidney failure.

Resident #12's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 5/22/16. Resident #12 was coded on the Brief Interview of Mental Status as unable to answer the questions, the staff assessment coded Resident #12 as being cognitively severely impaired for daily decision making. Resident #12 was also coded as requiring limited assistance of one person with physical assist for eating.

Resident #12 was observed at meals in her room without assistance or supervision on the following dates and times:
8/16/16 at 1:55 p.m. (snack), Resident #12 was observed with a small container of yoghurt on the bedside table in front of her, with a spoon.

3. Education for CNA's was initiated on 8/18 on how to accurately assess and document the percentage of meal intake, as well as how to supervise, provide verbal cuing, provide actual assistance as needed, and provide alternatives as needed. All CNA's will complete this education. New hire CNA's will be provided education during their orientation process. A communication form will be implemented for the CNA to communicate/document any resident change in PO intake to the nurse. All nursing staff will be educated on the use of this form. All professional staff (RN's and LPN's) will be educated on the standards for documentation. New hire RN's and LPN's will complete this education during their new hire orientation process. All professional staff (RN's and LPN's) will be educated on the standards for documentation. New hire RN's and LPN's will complete this education during their new hire orientation process.

4. An audit of 5% of those identified resident requiring verbal cueing or assistance with eating s will be done biweekly times two months. Results of audits will be presented to the Quarterly Quality Assurance Committee Meeting.

5. Corrective action will be completed October 1, 2016.
Resident #12 was not observed to be eating the yoghurt and there was a dried substance, same color as the yoghurt smeared over the bedside table. The spoon had not been used.

8/17/16 at 8:30 a.m. (breakfast). The breakfast tray was placed on the bedside table, Resident #12 was sitting up in bed and the bedside table was over her bed within reach of Resident #12 to easily eat her food. The tray stayed in front of Resident #12 for 30 minutes and during that time she did not attempt to feed herself.

8/17/16 at 12:30 p.m. (lunch). The lunch tray was set up on a bedside table in the hallway in front of Resident #12, who was seated in a wheelchair. Resident #12 moved the food items (a pureed consistency) around with her hands, picked up food items with her fingers and dropped the items into her drinks. She spilled a cup of orange colored liquid on the floor. There were no attempts observed to feed / cue / supervise Resident #12 during lunch.

8/18/16 at 8:45 a.m. (breakfast). A breakfast tray was set up on the bedside table and pushed into place over the bed. Resident #12 was seated upright in her bed. Resident #12 was observed picking up food items (pureed consistency) with her fingers and moving food items around the plate and table. She did not attempt to feed herself during the observation over a 30 minute period. CAN (certified nursing assistant) #7 did enter the room and sit on the bed and cue Resident #12 to eat. CNA #7 did not attempt to feed Resident #12. After a period of approximately two minutes, CNA #7 left the room, obtained a milk shake from the dining room and returned to Resident #12's room. CNA #7 offered Resident #12 the milkshake, placed it on the bedside table and left the room. Resident #12 did not eat or drink any food.

At 9:00 a.m., the
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eaten meal tray was removed from Resident #12's room by a resident helper with no further offers of alternate foods or assistance with feeding.

A review of Resident #12's nursing notes did not reveal any documentation that Resident #12 was not eating her meals.

Further review of Resident #12's clinical record revealed, in part, a nutrition assessment dated 5/24/16 that documented, "Continue Current Plan of Care. PO (by mouth) 50 - 75%.

A review of the meal logs for Resident #12 revealed, in part, that on the dates observed with a meal or a snack Resident #12 was documented as consuming the following percentages of her meal:
8/16/16 snack was not documented
8/17/16 breakfast consumed 0 (zero) percent
8/17/16 lunch consumed 0 percent
8/18/16 breakfast consumed 25 % - This surveyor observed this meal and Resident #12 only consumed one or two teaspoons of the meal.

A review of Resident #12's comprehensive care plan dated 5/5/14 revealed, in part, the following documentation: "Problem: The resident (Resident #12) has an ADL (activities of daily living) self-care performance deficit r/t (related to) dementia, she (Resident #12) dependent mainly for her adl care. She is able to feed herself after set up she may require assistance as she will allow. Interventions: Eating: The resident (Resident #12) requires set up assistance at times cues supervision. Date initiated 5/5/2014. Reviewed 5/26/16. Problem: Resident (Resident #12) is at nutritional risk related to continued
Statement of Deficiencies and Plan of Correction

**Provider/Supplier/Clinic Identification Number:** 495267

**Multiple Construction**

A. Building

B. Wing

**Date Survey Completed:** 08/18/2016

**Name of Provider or Supplier:** Brookside Rehab & Nursing Center

**Address:** 614 Hastings Lane, Warrenton, VA 20186

<table>
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<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
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<tr>
<td>F 312</td>
<td>Continued From page 96 unplanned/unexpected weight loss r/t refusal of foods and decline in po intake. 2/1/2015 - 10.1% x 6 months. Date initiated: 5/5/14. Revision on 5/28/15. Interventions: Alert nurse / dietician if not consuming on a routine basis. Further review of Resident #12's clinical record did not reveal any documentation that the dietician had been contacted in regards to low food intake. A review of Resident #12's Resident Care Card, posted on the inside surface of Resident #12's wardrobe, provided the following instruction: &quot;Eating, in room and tray set up only. Resident eats better when in room.&quot; On 8/17/16 at approximately 9:05 a.m. an interview was conducted with OSM (other staff member) #5, a resident helper. OSM #5 was asked how Resident #12 normally ate, OSM #5 stated, &quot;She does not get assistance, she eats by herself. I'm going to take her tray (breakfast) she's (Resident #12) not going to eat it. If she's hungry she'd eat it. She will eat at lunch time.&quot; OSM #5 was asked whether or not she should attempt to feed Resident #12 when she was not feeding herself. OSM #5 stated, &quot;I don't know, I'm not allowed.&quot; OSM #5 removed Resident #12's breakfast tray and disposed of the food. OSM #5 was observed to then go help other residents who were seated in the dining hall. An interview was conducted with CNA (certified nursing assistant) #7 on 8/18/16 at 9:05 a.m. CNA #7 was asked how much Resident #12 had consumed of her breakfast, CNA #7 stated, &quot;She (Resident #12) ate just a few bites even with me...&quot;</td>
<td>F 312</td>
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F 312. Continued From page 97

cuing her."

On 8/18/16 at 9:55 a.m. an interview was conducted with CNA #8. CNA #8 was asked if she observed a resident not eating food what would she do. CNA #8 stated, "I would assist / encourage if they can do for themselves I try to let them do as much as they can. When not eating for several days I will talk to the supervisor, either the lead CNA or the unit manager."

On 8/18/16 at 10:00 a.m. an interview was conducted with LPN (licensed practical nurse) #2, the MDS coordinator. LPN #2 was asked what nursing's responsibility was related to care plans. LPN #2 stated, "The expectation of nursing is to review the care plan and follow the directions as provided. That is the plan of care and what should be followed."

On 8/18/16 at 10:15 a.m. an interview was conducted with CNA #9. CNA #9 was asked what she should do if a resident was observed not eating a meal provided. CNA #9 stated, "I would try to encourage the resident to eat, if you give them the first bit it kind of encourages them to eat more. If a resident persisted with not eating I would sit down with the resident and I would try to help them, just encourage them to eat. If I wasn't successful I would let the nurse know that the resident was not eating." CNA #9 was asked what the concern would be if a resident wasn't eating. CNA #9 stated, "There may be something wrong with the resident, I would be concerned that the resident was not getting enough nutrition." CNA #9 was asked about Resident #12. CNA #9 stated, "When I've seen her (Resident #12) she will feed herself, she may use her fingers. I haven't worked with her in a couple
**F 312** Continued From page 98 of weeks."

On 8/18/16 at 10:17 a.m. an interview was conducted with LPN (licensed practical nurse) #12, Resident #12's care giver on the unit. LPN #12 was asked how she would know if any residents on the hallway were not eating their meals. LPN #12 stated, "The CNAs would tell me and I would go in and try to encourage the resident to eat." LPN #12 was asked if she was aware of a resident not eating her meals this week. LPN #12 stated she was not, the aides had not told her of anyone not eating. LPN #12 was asked if she was aware that Resident #12 had not been eating her meals, and had not eaten breakfast this morning. LPN #12 stated that she was not aware; the aides had not mentioned it. LPN #12 further stated, "(Name of Resident #12) often times will not eat. She does not like assistance and gets angry; she will sometimes drink the milkshake." LPN #12 was asked if she was aware of the care plan for Resident #12, LPN #12 stated that she was. LPN #12 was informed Resident #12's care plan documented that she required cues and supervision. LPN #12 was asked what cues and supervision meant. LPN #12 stated, "It means we would encourage her to eat and stop in her room to cue her." LPN #12 was asked if she had stopped in Resident #12's room during breakfast to supervise or cue her for eating. LPN #12 stated that she had not. LPN #12 was asked if she reviewed the meal logs, LPN #12 stated, "I review them every couple of days and when the doctor comes in for a recertification the doctor will review." LPN #12 was asked when she last reviewed the meal logs. LPN #12 was unable to answer.
F 312 Continued From page 99

On 8/18/16 at 11:00 a.m. an interview was conducted with CNA #7. CNA #7 was asked about Resident #12's ability to self feed. CNA #7 stated, "(Name of Resident #12) likes to feed herself but you have to try to encourage her. You have to supervise her eating and sit with her and cue her to eat. You just have to keep trying." CNA #7 was asked if Resident #12 had eaten her breakfast this morning, CNA #7 stated that she did not. CNA #7 was asked if Resident #12 normally ate her meals, CNA #7 stated, "She doesn't understand that she needs to eat and in the last month she has become worse."

On 8/18/16 at 11:15 a.m. ASM (administrative staff member) #2, the director of nursing, was made aware of the above findings. ASM #2 was asked whether or not she was aware that Resident #12 was not eating her meals. ASM #2 stated that she was unaware that Resident #12 was not eating. ASM #2 was shown the care plan for Resident #12 and asked what "supervise and cue" meant in regards to Resident #12's meals. ASM #2 stated, "It means to observe her meal and cue her to eat her meals. There is an assigned CNA to be on that unit and supervise, make sure that the resident is eating. Supervision is walking up and down the hallway to check on the residents." ASM #2 was asked if the aides saw that Resident #12 was not eating what should be done, ASM #2 stated, "They should attempt to cue her and spoon feed as she allows. She (Resident #12) should be offered an alternate food and it should be documented on the meal log."

A policy / reference titled "Feeding Techniques was provided to this surveyor for review,
F 312 Continued From page 100 documented, in part, the following: "Assisting Residents with Meals. Many residents can eat independently or with a little help from the staff. Other residents, however, need a lot of help or must be fed. These residents depend on the staff to meet their nutritional needs."

A review of the policy titled "Using the Care Plan" revealed, in part, the following documentation; "Policy Statement: The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. Policy Interpretation and Implementation: 3. CNA's are responsible for reporting to the Nurse Supervisor any change in the resident's condition and care plan goals and objectives that have not been met. 6. Documentation must be consistent with the resident's care plan."

No further information was provided prior to the end of the survey process.

F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

495267

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING

**(X3) DATE SURVEY COMPLETED**

08/18/2016

**NAME OF PROVIDER OR SUPPLIER**

BROOKSIDE REHAB & NURSING CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

614 HASTINGS LANE

WARRENTON, VA 20186

**(X4) ID PREFIX TAG**

**SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

**ID PREFIX TAG**

**PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**

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by:

Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to implement measures to prevent pressure sores for one of 25 residents in the survey sample; Resident #10.

For Resident #10, facility staff failed to apply bunny boots (1) per physician order.

The findings include:

Resident #10 was admitted to the facility on 1/21/14 and readmitted on 8/31/15 with diagnoses that included but were not limited to seizures, major depressive disorder, osteoarthritis, dementia with behavioral disturbance, high blood pressure, muscle wasting, atrophy and weakness.

Resident #10’s most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/24/16.

Resident #10’s was coded as being severely cognitively impaired in the ability to make daily decisions scoring three out of 10 on the BIMS (brief interview for mental status) exam. Resident #10 was coded as being totally dependent on staff with most ADLS (activities of daily living) and as requiring extensive assistance with meals.

On 8/17/16 at 8:16 a.m., Resident #10 was observed sitting up in her geri chair waiting for breakfast. She did not have bunny boots in place.

On 8/17/16 at 8:45 a.m., Resident #10 was observed sitting in her geri chair for breakfast. She did not have bunny boots in place.

On 8/17/16 at 9:41 a.m., Resident #10 was observed sitting in her geri chair. She did not

3. All nursing staff will be educated on skin care and prevention. A listing of all residents identified at risk, with ordered equipment/devices for prevention, will be made by the Wound Nurse. The Wound Nurse will be responsible to ensure such devices are utilized per physician order.

4. An audit of 25% of residents with order(s) for preventative devices/equipment will be done monthly times two months by the Wound Nurse or designee. Results of audits will be presented to the Quarterly Quality Assurance Committee.

5. Corrective action will be completed October 1, 2016.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>F 314</td>
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have bunny boots in place. On 8/17/16 at 11:30 a.m., Resident #10 was observed sitting in her geri chair. She did not have bunny boots in place. On 8/17/16 at 12:10 p.m., Resident #10 had her bunny boots in place. Review of Resident #10's POS (Physician Order Sheet) dated 7/31/16, documented the following order initiated on 3/02/16: "Bunny Boots out of bed in chair." Bunny boots were not on Resident #10's care plan. Review of Resident #10's resident care card (Kardex for the CNA [Certified Nursing Assistants]) revealed the following intervention: "Heel protector only when in geri-chair." Review of Resident #10's most recent Braden Scale Score (2) for predicting pressure sore risk dated, 4/21/16, documented that Resident #10 scored an "11" indicating that she was a high risk for pressure sore development. Review of Resident #10's August 2016 TAR (Treatment Administration Record) revealed that the nurse had not signed off that the bunny boots were in place during these times on 8/17/16. A signature was added to the TAR after the bunny boots were applied. On 8/18/16 at 11:22 a.m., observation of Resident #10's heels was conducted. No concerns were identified. On 8/17/16 at 4:09 p.m. an interview was conducted with LPN (Licensed Practical Nurse) #1, the unit manager of the Alzheimer's unit. When asked how CNAs know what skin preventive measures to put into place for each resident, LPN #1 stated that there is a care card in each resident's closet documenting what each resident needs. When asked who updates the care cards, LPN #1 stated the lead CNA or the
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<td>F 314</td>
<td>Continued From page 103 nurses. LPN #1 stated that sometimes she will update them. She stated that if there is an order for a skin preventive measure or it is on the care plan, then the interventions should also be on the care card for the CNA to follow. LPN #1 stated that if there is an order for an intervention to be put into place than it should be put into place. On 8/18/16 at 8:45 a.m., an interview was conducted with CNA (certified nursing assistant) #5, a CNA who regularly works with Resident #10. When asked how CNA's know what a resident needs for skin prevention, CNA #5 stated that the CNA's look at the resident's care card that is updated by the nurses or the CNAs per verbal report from the nurses. When asked if Resident #10 wears bunny boots, CNA #5 stated that the resident has always worn them while she was in her chair to protect her heels. When asked if they were on yesterday morning, CNA #5 stated that she did not get Resident #10 out of bed and was not the CNA for Resident #10 that day. She stated that the night shift may not have been aware that the resident needed bunny boots. When asked where the care card is located for each resident, CNA #5 stated it was in the inside of the resident's closet. On 8/18/16 at 8:50 a.m., an interview was conducted with CNA #6, the CNA who had the resident on 8/17/16 day shift. When asked how CNA's know what a resident needs for skin prevention, CNA #6 stated that the CNAs have a care card that they can use as a reference that is located in the closet for each resident. When asked who updated the care card, CNA #6 stated the CNA's update based on a verbal report from the nurse, or the nurse updates the care card. When asked if she was assigned to Resident #10 that day, CNA #6 stated that she was assigned at 6:30 a.m. to Resident #10 after there was a call</td>
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F 314 Continued From page 104

out. When asked if Resident #10 needed bunny boots for her heels, CNA #6 stated, "I really don't have her often. I would have to look at the care card." When asked if Resident #10 had bunny boots in place on 8/17/16 during the morning, CNA #6 stated that she personally did not put boots on her and she did not look at the care card. She also stated that 11-7 shift got the resident up for breakfast. When asked who put the bunny boots on the resident at noon, CNA #6 stated that she was not sure and that it was not her.

On 8/18/16 at 10:10 a.m., ASM #2, the DON (Director of Nursing) was made aware of the above concerns. She stated that the facility uses Lippincott as a reference for providing nursing care. No further information was presented prior to exit.

According to Lippincott Manual of Nursing Practice, Eighth Edition, part 2, unit 1, section 9, special health problems of the older adult, page 187, "nursing and patient care considerations in prevention and healing of pressure ulcers; relieve the pressure by: reposition every two hours, using special devices to cushion specific areas such as the heels."

1) Bunny Boots-is a fleece cushion heel protector used for redistributing pressure to prevent pressure sores of the heels. This information was obtained from The National Institutes of Health.


2) Braden Scale: The Braden Scale for Predicting Pressure Sore Risk is a clinically validated tool that allows nurses and other health care providers to reliably score a patient/client's level
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<td>Continued From page 105 of risk for developing pressure ulcers</td>
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<td>F 329 SS=D</td>
<td>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</td>
<td>F 329</td>
<td>1. The Tylenol order for resident #4 was discontinued on 8/18/16. The Lasix order and Ferrous Gluconate orders for resident #15 were clarified on 8/18/16 and corrected on the MAR.</td>
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<td>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</td>
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<td>2. An audit of all new medication orders received for the past three months to ensure that they were accurately documented and implemented. This audit will be completed by the DON, ADON, UMs, or designee.</td>
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<td>3. All new physician orders will be reviewed by the SOC review team, who meets Monday through Friday. This review will include observation of the MAR to ensure verification that the order is transcribed correctly on the MAR.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure residents were free from unnecessary medications for two of 25</td>
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<td>From the 21st of the month until the end of the month the Supervisor will review all new medication orders to ensure that new orders are transcribed correctly/accurately on the current and upcoming months' MAR.</td>
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residents in the survey sample, Residents #4 and #15.

1. On 7/16/16 Resident #4’s physician gave an order for Tylenol 650 mg (milligrams) every four hours as needed times 48 hours. The facility staff administered Tylenol 650 mg to the resident once on 7/23/16 and once on 7/24/16.

2a. Facility staff administered ferrous gluconate 240 milligrams (1) twice a day for 17 days for Resident #15 after the physician discontinued the medication on 7/29/16.

2b. Facility staff administered Lasix 40 mg (2) once a day for 17 days for Resident #15 after the physician ordered Lasix 20 mg.

The findings include:

1. On 7/16/16 Resident #4’s physician gave an order for Tylenol (used to relieve mild to moderate pain) (1) (650 mg (milligrams) every four hours as needed times 48 hours. The facility staff administered Tylenol 650 mg to the resident once on 7/23/16 and once on 7/24/16.

Resident #4 was admitted to the facility on 9/27/11. Resident #4’s diagnoses included but were not limited to: dementia (2), osteoarthritis (3) and gout (4). Resident #4’s most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 7/3/16, coded the resident’s cognition as severely impaired. Section J documented Resident #4 had not voiced any complaints of pain during the five day look back period.

Review of Resident #4’s clinical record revealed a

4. 10% of all new orders will be audited monthly times two months to ensure all new medication orders received were accurately documented by the DON, ADON, UMs, or designee. Results of audits will be presented at the Quarterly Quality Assurance Committee.

5. Corrective action will be completed October 1, 2016.
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| F 329        | Continued From page 107 physician's order dated 7/16/16 that documented, "Tylenol 650 mg (milligrams) po (by mouth) q(every) 4 (hours) PRN (as needed) for discomfort x(times) 48 (hours) then notify md (medical doctor)." Resident #4's July 2016 MAR (medication administration record) revealed the resident was administered Tylenol 650 mg once on 7/23/16 and once on 7/24/16. Resident #4's comprehensive care plan revised on 7/12/15 documented, "The resident has Arthritis/ She is at risk for pain...Interventions: Give analgesics as ordered by the physician..." On 8/17/16 at 7:35 a.m., an interview was conducted with LPN (licensed practical nurse) #4 (the nurse who administered Tylenol to Resident #4 on 7/24/16). LPN #4 was asked to read the above order. LPN #4 stated, "Based on the order it (the Tylenol) can't be given after 48 hours. Did I give it?" LPN #4 was shown Resident #4's July 2016 MAR. LPN #4 stated, "I did. That's a med error." On 8/17/16 at 3:00 p.m., an interview was conducted with RN (registered nurse) #2 (the nurse who administered Tylenol to Resident #4 on 7/23/16). RN #2 was asked to read the above order. RN #2 was asked if the Tylenol could be given after the 48 hour time period. RN #2 stated, "No." On 8/17/16 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The facility pharmacy policy titled, "6.0 General Dose Preparation and Medication Administration"
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| F 329             | Continued From page 108 documented in part, "Applicability: This Policy 6.0 sets forth the procedures relating to general dose preparation and medication administration. Facility staff should also refer to Facility policy regarding medication administration and should comply with Applicable Law and the State Operations Manual when administering medications. Procedure...4. Prior to administration of medication, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: 4.1 Facility staff should: 4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident..." No further information was presented prior to exit. (1) This information was obtained from the website: This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html (2) "Dementia is not a specific disease. It is a descriptive term for a collection of symptoms that can be caused by a number of disorders that affect the brain. People with dementia have significantly impaired intellectual functioning that interferes with normal activities and relationships. They also lose their ability to solve problems and maintain emotional control, and they may experience personality changes and behavioral problems, such as agitation, delusions, and hallucinations..." This information was obtained from the website: http://www.ninds.nih.gov/disorders/dementias/dementia.htm (3) "Osteoarthritis is the most common form of
Continued From page 109

Arthritis. It causes pain, swelling, and reduced motion in joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine.” This information was obtained from the website:
https://medlineplus.gov/osteoarthritis.html
(4) "Gout is a common, painful form of arthritis. It causes swollen, red, hot and stiff joints.” This information was obtained from the website:

2a. Facility staff administered ferrous gluconate 240 milligrams (1) twice a day for 17 days for Resident #15 after the physician discontinued to the medication on 7/29/16.

Resident #15 was admitted to the facility on 7/1/14 with diagnoses that included but were not limited to: difficulty swallowing, elevated cholesterol, diabetes and depression.

The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 6/29/16 coded the resident as having an 11 out 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired cognitively to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the physician’s orders dated and signed on 7/29/16 documented, "FERROUS GLUCONATE 240MG (milligrams)... 1 TAB BY MOUTH TWICE DAILY...” There was a line
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<tr>
<td>F 329</td>
<td>Continued From page 110 drawn into the medication and a &quot;D/C (discontinue)&quot; was documented. Review of the August 2016 MAR (medication administration record) documented, &quot;FERROUS GLUCONATE 240MG...1 TAB BY MOUTH TWICE DAILY...&quot; It was documented as being administered twice a day from 8/1/16 to 8/16/16 and once on 8/17/16 for a total of 31 doses. An interview was conducted on 8/17/16 at 3:35 p.m. with LPN (licensed practical nurse) #8, the nurse who administered medications to Resident #15 that day. When asked to review the physician's orders dated 7/29/16 for the ferrous gluconate, LPN #8 stated, &quot;I would think that should have been d/c'd (discontinued) on 7/29/16.&quot; When asked the process staff followed when a medication was discontinued, LPN #8 stated, &quot;If it got d/c'd that day, whoever came in to note that the doctor was in to sign the POS (physician order set) and then when they did that (signed the POS) they should have looked to see if there was anything new ordered as he did and then d/c'd it on the MAR. Yellow it out so you know to no longer given it and call the RP (responsible party).&quot; When asked to review the August 2016 MAR for the ferrous gluconate, LPN #8 stated, &quot;That was my fault, I didn't discontinue it.&quot; LPN #8 then took a yellow highlighter and colored out the order on the MAR for the ferrous gluconate. An interview was conducted on 8/17/16 at 3:45 p.m. with RN (registered nurse) #1, the assistant director of nursing and LPN #3, the unit manager. When asked to review the physician's orders dated 7/29/16 for the ferrous gluconate, RN #1 stated, &quot;He d/c'd the iron (ferrous gluconate).&quot;</td>
<td>F 329</td>
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</tbody>
</table>
**STRICTLY CONFIDENTIAL**

### Statement of Deficiencies and Plan of Correction

#### Name of Provider or Supplier

**Brookside Rehab & Nursing Center**

**Address:** 614 Hastings Lane, Warrenton, VA 20186

<table>
<thead>
<tr>
<th>ID Prefix</th>
<th>TAG</th>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 329</td>
<td></td>
<td>Continued From page 111</td>
<td>F 329</td>
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</table>

When asked the process staff followed regarding changes in the POS, LPN #3 stated, "The nurse should come along and note it and make the necessary changes." LPN #3 stated that the order should have been faxed to the pharmacy for the changes to be made on the MAR. RN #1 and LPN #3 reviewed Resident #15's August 2016 MAR and stated that the ferrous gluconate should have been discontinued and not given.

On 8/17/16 at 5:49 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled "General Dose Preparation and Medication Administration" documented, "Procedure: Prior to administration of medication, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: 4.1.2. Confirm that the MAR reflects the most recent medication order."

No further information was provided prior to exit.

(1) Ferrous gluconate -- Iron is a mineral that is naturally present in many foods, added to some food products, and available as a dietary supplement. Iron is an essential component of hemoglobin, an erythrocyte protein that transfers oxygen from the lungs to the tissues. This information was obtained from:


2b. Facility staff administered Lasix 40 mg (2) once a day for 17 days for Resident #15 after the...
Continued from page 112

physician ordered Lasix 20 mg.

Review of the physician's orders signed and dated on 7/29/16 documented, "FUROSEMIDE (1) 40MG TABLET...TAKE 1 TAB BY MOUTH EVERY MORNING FOR GENERAL EDEMA."

Next to the order was an arrow and an arrow pointing down (meaning decrease) "20 mg po (by mouth) q (every) day."

Review of the August 2016 MAR documented, "FUROSEMIDE 40MG TABLET...TAKE 1 TAB BY MOUTH EVERY MORNING FOR GENERAL EDEMA." Lasix 40 mg was documented as being administered every day from 8/1/16 to 8/17/16, a total of 17 doses.

An interview was conducted on 8/17/16 at 3:45 p.m. with RN (registered nurse) #1, the assistant director of nursing and LPN #3, the unit manager. When asked to review the physician's orders dated 7/29/16 for the furosemide, RN #1 stated, "He (the physician) decreased the dose to 20 mg." When asked the process staff followed regarding changes in the POS, LPN #3 stated, "The nurse should come along and note it and make the necessary changes." LPN #3 stated that the order should have been faxed to the pharmacy for the changes to be made on the MAR. RN #1 and LPN #3 reviewed Resident #15's August 2016 MAR and stated that the wrong dose of furosemide had been given.

On 8/17/16 at 5:49 p.m. ASM #1 and ASM #2 were made aware of the findings.

On 8/18/16 at 9:05 a.m. a request for a copy of the facility's policy on monthly physician order recapitulation was requested from ASM #2.
F 329 Continued From page 113

On 8/18/16 at 1:20 p.m. ASM #2 stated she had not received the policy from the pharmacy.

No further information was provided prior to exit.

According to Fundamentals of Nursing, 6th edition, 2001: Patricia A. Potter and Anne Griffin Perry, Mosby, Inc, page 852, "Check accuracy and completeness of each MAR or computer printout with prescriber's written medication order."

In Potter-Perry, Fundamentals of Nursing, 6th edition, page 841, a noted standard of practice is: "When medications are first ordered, the nurse compares the medication recording form or computer orders with the prescriber's written orders." On page 852, regarding the administration of oral medications, "Check accuracy and completeness of each MAR or computer printout with prescriber's written medication order."

(1) Furosemide – Furosemide is a potent diuretic which, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte depletion. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=69b21dfe-30a0-405b-b39b-c19cea7ad966

F 332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced

F 332

1. The Lasix order and Ferrous Gluconate orders for resident #15 were clarified on 8/18/16 and corrected/discontinued on the MAR.

RN #4 and RN #3 were counseled by the Director of Nursing regarding medication errors identified during their medication pass for residents #15 and #16. Both RNs were educated on 8/19/16 on the current medication administration standards.
Continued From page 114 by:

Based on observation, staff interview, facility policy review and clinical record review it was determined facility staff failed to ensure the facility was free of medication error rate of 5% or more. Facility staff had a 12.9% medication error rate due to four medication errors out of 30 medications given on two out of five residents in the medication administration observations on 8/16/16 and 8/17/16 for Resident #15 and Resident #16.

1. Facility staff administered ferrous gluconate (6) 240 mg (milligrams) to Resident #15 on 8/16/16 at 4:30 p.m. when the physician had discontinued the medication on 7/29/16.

2 a. On 8/17/16 at 8:12 a.m., during the medication administration observation, facility staff administered five (5) units of regular insulin to Resident #16, instead of the physician's ordered 10 units of regular insulin and administered 35 units of NPH insulin to Resident #16, instead of the 30 units ordered by the physician.

2 b. Facility staff failed to instruct Resident #16 to rinse out her mouth after taking the Advair inhaler as ordered during the medication administration observation on 8/17/16 at 8:12 a.m.

The findings include:

1. Resident #15 was admitted to the facility on 7/1/14 with diagnoses that included but were not limited to: diabetes, elevated cholesterol, depression, difficulty swallowing and high blood pressure.

2. An audit of all new medication orders received for the past three months to ensure that they were accurately documented and implemented. This audit will be completed by the DON, ADON, UMs, or designee

3. All professional nursing staff (RN's and LPN's) will be educated on medication pass standards. This education will be provided by the Pharmacy. Each nurse will be observed during a medication pass for compliance with standards and competency. New hire RN's and LPN's will be educated on medication pass standards during their orientation process. New hire RN's and LPN's will be observed during a medication pass for compliance with standards and competency.

All new medication orders will be reviewed by the SOC review team, who meets Monday through Friday. This review will include observation of the MAR to ensure verification that order is transcribed correctly on the MAR. From the 21st of the month until the end of the month the Supervisor, or designee, will review all new medication orders to ensure that new orders are transcribed correctly/accurately on the current and upcoming months’ MAR.
**F 332** Continued From page 115

The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 6/29/16 coded the resident as having an 11 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions.

An observation was made on 8/16/16 at 4:30 p.m. of the medication administration with RN (registered nurse) #4 for Resident #15. The following medications were taken from the medication cart and put into a medication cup, after each medication was taken from the pill package, the package was given to the surveyor to document the medication: Atorvastatin 40 mg (milligrams) (1); Buspar 5 mg (2); Glimperide 2 mg (3); Metformin 500 mg (4); Seroquel 12.5 mg (5) and FeGluconate 240 mg (6). The medications were crushed, put in applesauce and taken into Resident #15’s room and given to the resident.

Review of Resident #15’s physician’s orders dated and signed on 7/29/16 revealed that all of the medications were administered as ordered with the exception of the ferrous gluconate. The physician’s order documented, “FERROUS GLUCONATE 240MG 1 TAB BY MOUTH TWICE DAILY.” There was a line through the medication and a “D/C (discontinue)” with a line under it next to the medication.

Review of Resident #15’s July and August 2016 MAR (medication administration record) documented, “FERROUS GLUCONATE 240 MG 1 TAB BY MOUTH TWICE DAILY.” Review of the July and August 2016 MARS documented that the resident received the ferrous gluconate on 31 occasions after it was discontinued.

4. A 10% of all new orders will be audited by the DON, ADON, UMs, or designee monthly times two months to ensure that they were accurately documented.

Medication pass observation audits will be done weekly times one month by the DON, ADON, UMs, or designee. Then biweekly times one month. Results of audits will be presented to the facility’s Quarterly Quality Assurance Meeting.

5. Correction action will be complete October 1, 2016.
F 332 Continued From page 116

An interview was conducted on 8/17/16 at 3:35 p.m. with LPN (licensed practical nurse) #8, the nurse who administered medications to Resident #15 that day. When asked to review the physician's orders dated 7/29/16 for the ferrous gluconate, LPN #8 stated, "I would think that should have been d/c'd on 7/29/16." When asked the process staff followed when a medication was discontinued, LPN #8 stated, "If it got d/c'd that day, whoever came in to note that the doctor was in to sign the POS (physician order set) and then when they did that (signed the POS) they should have looked to see if there was anything new ordered as he (the physician) did (order something new) and then d/c'd it on the MAR. Yellow it out so you know to no longer give it and call the RP (responsible party)." When asked to review the August 2016 MAR for the ferrous gluconate, LPN #8 stated, "That was my fault, I didn't discontinue it." LPN #8 then took a yellow highlighter and colored out the order on the MAR for the ferrous gluconate.

An interview was conducted on 8/17/16 at 3:45 p.m. with RN (registered nurse) #1, the assistant director of nursing and LPN #3, the unit manager. When asked to review the physician's orders dated 7/29/16 for the ferrous gluconate, RN #1 stated, "He (the physician) d/c'd the iron (ferrous gluconate)." When asked the process staff followed regarding changes in the POS, LPN #3 stated, "The nurse should come along and note it and make the necessary changes." LPN #3 stated that the order should have been faxed to the pharmacy for the changes to be made on the MAR. RN #1 and LPN #3 reviewed Resident #15’s August 2016 MAR and stated that the ferrous gluconate should have been discontinued.

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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</thead>
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<td>F 332</td>
<td>An interview was conducted on 8/17/16 at 3:35 p.m. with LPN (licensed practical nurse) #8, the nurse who administered medications to Resident #15 that day. When asked to review the physician's orders dated 7/29/16 for the ferrous gluconate, LPN #8 stated, &quot;I would think that should have been d/c'd on 7/29/16.&quot; When asked the process staff followed when a medication was discontinued, LPN #8 stated, &quot;If it got d/c'd that day, whoever came in to note that the doctor was in to sign the POS (physician order set) and then when they did that (signed the POS) they should have looked to see if there was anything new ordered as he (the physician) did (order something new) and then d/c'd it on the MAR. Yellow it out so you know to no longer give it and call the RP (responsible party).&quot; When asked to review the August 2016 MAR for the ferrous gluconate, LPN #8 stated, &quot;That was my fault, I didn't discontinue it.&quot; LPN #8 then took a yellow highlighter and colored out the order on the MAR for the ferrous gluconate. An interview was conducted on 8/17/16 at 3:45 p.m. with RN (registered nurse) #1, the assistant director of nursing and LPN #3, the unit manager. When asked to review the physician's orders dated 7/29/16 for the ferrous gluconate, RN #1 stated, &quot;He (the physician) d/c'd the iron (ferrous gluconate).&quot; When asked the process staff followed regarding changes in the POS, LPN #3 stated, &quot;The nurse should come along and note it and make the necessary changes.&quot; LPN #3 stated that the order should have been faxed to the pharmacy for the changes to be made on the MAR. RN #1 and LPN #3 reviewed Resident #15’s August 2016 MAR and stated that the ferrous gluconate should have been discontinued.</td>
</tr>
</tbody>
</table>
F 332 Continued From page 117 and not given.

On 8/17/16 at 5:49 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

On 8/18/16 at 9:02 a.m. a request was made to ASM #2 for the facility's policy on medication recapitulation.

On 8/18/16 at 1:20 p.m. ASM #2 stated she had not received the policy from the pharmacy.

Review of the facility's policy titled "General Dose Preparation and Medication Administration" documented, "Procedure: Prior to administration of medication, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: 4.1.2. Confirm that the MAR reflects the most recent medication order."

No further information was provided prior to exit.

(1) Atorvastatin -- Atorvastatin is a commonly used cholesterol lowering agent (statin) that is associated with mild, asymptomatic and self-limited serum aminotransferase elevations during therapy and rarely with clinically apparent acute liver injury. This information was obtained from: http://livertox.nih.gov/Atorvastatin.htm

(2) Buspar -- BuSpar® (buspirone hydrochloride tablets, USP) is an antianxiety agent that is not chemically or pharmacologically related to the benzodiazepines, barbiturates, or other sedative/anxiolytic drugs. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/archives/fd
F 332 Continued From page 118

aDrugInfo.cfm?archiveId=41422

(3) Glimperide -- Glimperide tablets USP are indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. This information was obtained from:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=9b74fbac-9e04-4927-9981-1e3dace89c6d#section-1

(4) Metformin -- Metformin is a first line agent for the treatment of type 2 diabetes that can be used alone or in combination with sulfonylureas, thiazolidinediones or other hypoglycemic agents. This information was obtained from:
http://livertox.nih.gov/Metformin.htm

(5) Seroquel -- SEROQUEL ® (quetiapine fumarate) is a psychotropic agent belonging to a chemical class, the dibenzothiazepine derivatives. This information was obtained from:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=b007bac6-a207-481c-8aba-03ade1dd6a88

(6) Ferrous gluconate -- Iron is a mineral that is naturally present in many foods, added to some food products, and available as a dietary supplement. Iron is an essential component of hemoglobin, an erythrocyte protein that transfers oxygen from the lungs to the tissues. This information was obtained from:

2. a. On 8/17/16 at 8:12 a.m., during the medication administration observation, facility staff administered 5 units of regular insulin to Resident #16, instead of the physician's ordered 10 units of regular insulin and administered 35 units of NPH insulin to Resident #16, instead of
F 332 Continued From page 119

the 30 units ordered by the physician.

Resident #16 was admitted to the facility on 7/31/08 and readmitted on 9/5/14 with diagnoses that included but were not limited to: diabetes, arthritis, dementia and obesity.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 6/1/16 coded the resident as having a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions.

An observation was made on 8/17/16 at 8:12 a.m. of the medication administration with RN (registered nurse) #3. RN #3 removed the following medications from the medication cart for Resident #16, after each medication was put into the medication cup or drawn up into the syringe it was handed to the surveyor to document: Fexofenadine 60 mg (1); Lasix 40 mg (2); Magnesium oxide 400 mg (3); Nadolol 20 mg (4); Metformin 500 mg; Biotene (5); Robafen 10cc (cubic centimeters) (6); Advair 250/50 mcg (micrograms) (7); Bepreve 1.5% eye drops (8); Pataday 0.2% eye drops (9); and Artificial tears 1.4% eye drops; Humulin R (regular insulin) (10) 5 units and Humulin NPH (11) 35 units.

Humulin regular insulin 5 units was drawn up into an insulin syringe and handed to the surveyor. The plunger on the syringe was pulled back to the 10 unit mark; there were 5 units of insulin observed in the syringe. RN #3 then took the syringe and put the needle into the Humulin N insulin vial and drew up the medication and handed it to the surveyor, there were a total of 40 units of insulin in the syringe indicating that 35
Continued from page 120,

units of the Humulin N insulin were added to the syringe to the five units of regular insulin. LPN #3 then took the medication into Resident #16's room and administered the insulin to the resident.

Review of Resident #16's physician's orders dated 7/11/16 revealed that all of the medications were administered as ordered with the exception of the regular and long lasting insulin. The physician order documented: "HUMULIN R (regular) 10 UNITS. SUBCUTANEOUSLY THREE TIMES DAILY; HUMULIN N (NPH) 30 UNITS SUBCUTANEOUSLY EVERY 12 HOURS."

Review of the August MAR documented, "HUMULIN R. INJECT 10 UNITS SUBCUTANEOUSLY THREE TIMES DAILY. HUMULIN N. INJECT 30 UNITS SUBCUTANEOUSLY EVERY 12 HOURS." RN #3 documented that the resident had received the medication on 8/17/16 at 8:00 a.m.

Resident #16 received five units of the Humulin regular insulin instead of the physician ordered ten units. The resident received 35 units of Humulin N (NPH) insulin instead of the physician ordered 30 units.

An interview was conducted on 8/17/16 at 10:50 a.m. with LPN #3, the unit manager. When asked what staff did when drawing up insulin, LPN #3 stated that after they had drawn up the insulin they had to check for air bubbles to make sure the right amount of insulin was in the syringe. LPN #3 was asked if the syringe contained a total of 40 units of insulin and five units were regular insulin how many units of NPH insulin was given to the resident, LPN #3 stated, "She gave 35 units of NPH."
**Continued From page 121**

An interview was conducted on 8/17/16 at 10:55 a.m. with RN #3. When asked if she had checked for an air bubble in the insulin syringe, RN #3 stated she thought she had. When she was made aware of the observation and asked how many units of regular insulin did the resident receive, RN #3 stated, "Five" when asked how many units of regular insulin were ordered, RN #3 stated, "Ten". When asked how many units of NPH insulin was administered to the resident, RN #3 stated, "35" when asked how many units of NPH insulin were ordered, RN #3 stated, "30."

On 8/17/16 at 5:49 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "General Dose Preparation and Medication Administration." documented, "Procedure: 3. Dose Preparation: Facility should take all measures required by Facility policy and Applicable Law, including, but no limited to the following: 3.7 Facility staff should verify that the medication name and dose are correct and should inspect the medication for contamination...."

2 b. Facility staff failed to instruct Resident #16 to rinse out her mouth after taking the Advair Inhaler as ordered during the medication administration observation on 8/17/16 at 8:12 a.m.

An observation was made on 8/17/16 at 8:12 a.m. with RN #3 of the medication administration. RN #3 took Resident #16's Advair inhaler out of the medication cart and took it into the resident's...
Continued From page 122

room. RN #3 gave the inhaler to the resident who used it and handed it back to the nurse. The nurse did not have the resident rinse out her mouth following the use of the inhaler.

An interview was conducted on 8/17/16 at 10:50 p.m. with LPN #3. When asked how the medication from an inhaler was administered, LPN #3 stated, "You get it out of the cart, check and make sure it's for the right resident and the right medication. Check it too visually to make sure it's clean and have the resident use the inhaler. I bring in two cups, one with water and one empty so they can rinse and spit (after using the inhaler)."

An interview was conducted on 8/17/15 at 10:55 a.m. with RN #3. When asked if a resident should do anything after using an inhaler, RN #3 stated, "They should rinse." When asked if Resident #15 had rinsed her mouth after using the inhaler, RN #3 stated, "No we did not, it's my fault, she has a history of not rinsing."

On 8/17/16 at 5:49 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "General Dose Preparation and Medication Administration." documented, "Procedure: 5.7 Provide the resident with any necessary instructions (e.g. using an inhaler)."

"How to use your ADVAIR HFA inhaler: Step 7. Rinse your mouth with water after breathing in the medicine. Spit out the water. Do not swallow it." This information was obtained from the website:
No further information was provided prior to exit.

(1) Fexofenadine -- Fexofenadine is a second generation antihistamine that is used for the treatment of allergic rhinitis, angioedema and chronic urticaria. This information was obtained from: http://livertox.nih.gov/Fexofenadine.htm

(2) Lasix – 1) Furosemide -- Furosemide is a potent diuretic which, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte depletion. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=59b21db8-30a0-405b-b39e-c19ce7ad9d6

(3) Magnesium oxide – Relieves: acid indigestion, upset stomach. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d3c5b01b-f0d6-4503-ab18-b1a7236e2c6

(4) Nadolol – Nadolol and bendrofluamide tablets are indicated for the treatment of hypertension, to lower blood pressure. Lowering blood pressure reduces the risk of fatal and nonfatal cardiovascular events, primarily strokes and myocardial infarctions. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d2d226ea-1624-47ee-82bf-e9660b75029f

(5) Biotene -- aids in the prevention of dental cavities This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=1101c17f-c648-4cd5-a7cd-679b59db0e1
F 332 Continued From page 124

6. Robafen -- helps loosen phlegm (mucus) and thin bronchial secretions to make coughs more productive. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=272a2819-9713-4e33-a14e-8be6f8bfebf8

7. Advair -- ADVAIR DISKUS is indicated for the treatment of asthma in patients aged 4 years and older. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=f53cb2d5-3267-401e-9393-dff8357830d4

8. Bepreve -- BEPREVE (Trademark) (bepotastine besilate ophthalmic solution) 1.5% is a histamine H1 receptor antagonist indicated for the treatment of itching associated with signs and symptoms of allergic conjunctivitis. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=7c77517f-24c7-4778-94a7-873d11c3c657

9. Pataday -- PATADAY (Trademark) solution is indicated for the treatment of ocular itching associated with allergic conjunctivitis. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=e1eb5130-e59d-4590-8b04-7b1a6adade5bd

10. Humulin R -- HUMULIN R U-500 is concentrated human insulin indicated to improve glycemic control in adult and pediatric patients with diabetes mellitus requiring more than 200 units of insulin per day. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=b50e8dd0-1d48-4dc9-87fd-e14675255e8c

11. Humulin NPH -- HUMULIN N is
<table>
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<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 332</td>
<td>Continued From page 125 intermediate-acting recombinant human insulin indicated to improve glycemic control in adults and pediatric patients with diabetes mellitus. This information was obtained from: <a href="https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?id=f6edd793-440b-40c2-96b5-c16133b7a921">https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?id=f6edd793-440b-40c2-96b5-c16133b7a921</a></td>
<td>F 332</td>
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<tr>
<td>F 333 SS=D</td>
<td>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</td>
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The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure that one of 25 residents in the survey sample were free from a significant medication error, Resident #16.

Facility staff administered five (5) units of Humulin R (regular insulin) and 35 units of Humulin N (NPH) insulin (2) to Resident #16 on 8/17/16 at 8:12 a.m. during the medication administration observation rather than then the physician ordered Humulin R 10 units and Humulin N 30 units.

The findings include:

Resident #16 was admitted to the facility on 7/31/08 and readmitted on 9/5/14 with diagnoses that included but were not limited to: diabetes, arthritis, dementia and obesity.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1 PROVIDER/SUPPLIER/COLA IDENTIFICATION NUMBER:**

495267

**X2 MULTIPLE CONSTRUCTION**

A. BUILDING

B. WING

**X3 DATE SURVEY COMPLETED**

C 08/18/2016

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**NAME OF PROVIDER OR SUPPLIER**

BROOKSIDE REHAB & NURSING CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

614 HASTINGS LANE

WARRENTON, VA 20186

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<table>
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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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</table>
| F 333 | Continued From page 126 | The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 6/1/16 coded the resident as having a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. An observation was made on 8/17/16 at 8:12 a.m. of the medication administration with RN (registered nurse) #3. Humulin R (regular) insulin was drawn up into an insulin syringe and handed to the surveyor. The plunger on the syringe was pulled back to the 10 unit mark there were fine (5) units of insulin observed in the syringe. RN #3 then took the syringe and put the needle into the Humulin N (NPH) insulin vial and drew up the medication and handed it to the surveyor, there were a total of 40 units of insulin in the syringe indicating that 35 units of the Humulin N insulin were added to the five units of regular insulin in the syringe. LPN #3 then took the medication into Resident #16's room and administered the insulin to the resident. Review of Resident #16's physician's orders dated 7/11/16 revealed that all of the medications were administered as ordered with the exception of the regular and long lasting insulin. The physician order documented: "HUMULIN R (regular) 10 UNITS. SUBCUTANEOUSLY THREE TIMES DAILY; HUMULIN N (NPH) 30 UNITS SUBCUTANEOUSLY EVERY 12 HOURS."

Review of the August MAR documented, "HUMULIN R. INJECT 10 UNITS SUBCUTANEOUSLY THREE TIMES DAILY. HUMULIN N. INJECT 30 UNITS SUBCUTANEOUSLY EVERY 12 HOURS." RN #3 documented that the resident had received the | | | | | | |

4. Medication pass observation audits, including insulin administration will be done weekly times one month by the DON, ADON, UMs, or designee. Then, biweekly times one month. Results of audits will be presented to the facility's Quarterly Quality Assurance Meeting.

5. Correction action will be completed October 1, 2016.

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**FORM CMS-2557(02-99) Previous Versions Obsolete**

Event ID: FV2R11

Facility ID: VA0178

If continuation sheet Page 127 of 164
Continued From page 127 remedication on 8/17/16 at 8:00 a.m.

Resident #16 received five units of the Humulin regular insulin instead of the physician ordered ten units. The resident received 35 units of Humulin N (NPH) insulin instead of the physician ordered 30 units.

An interview was conducted on 8/17/16 at 10:50 a.m. with LPN #3, the unit manager. When asked what staff did when drawing up insulin, LPN #3 stated that after they had drawn up the insulin they had to check for air bubbles to make sure the right amount of insulin was in the syringe. LPN #3 was asked if the syringe contained a total of 40 units of insulin and five units were regular insulin how many units of NPH insulin was given to the resident, LPN #3 stated, "She gave 35 units of NPH."

An interview was conducted on 8/17/16 at 10:55 a.m. with RN #3. When asked if she had checked for an air bubble in the insulin syringe, RN #3 stated she thought she had. When she was made aware of the observation and asked how many units of regular insulin was administered to the resident, RN #3 stated, "Five" when asked how many units of regular insulin were ordered, RN #3 stated, "Ten". When asked how many units of NPH insulin the resident had received, RN #3 stated, "35" when asked how many units of NPH insulin were ordered, RN #3 stated, "30."

On 8/17/16 at 5:49 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "General Dose
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| F 333         | Continued From page 128 Preparation and Medication Administration."
|               | documented, "Procedure: 3. Dose Preparation: Facility should take all measures required by Facility policy and Applicable Law, including, but no limited to the following: 3.7 Facility staff should verify that the medication name and dose are correct and should inspect the medication for contamination...."
|               | No further information was provided prior to exit. According to the American Diabetes Association, they describe, "Insulin" as potentially one of the most dangerous medications that a medication technician/nurse will administer. Residents require sliding scale insulin to help control blood sugar levels. If too much insulin is administered, a resident's blood sugar can fall too low. If not enough insulin is administered, the blood sugar can remain too high."

(1) Humulin R -- HUMULIN R U-500 is concentrated human insulin indicated to improve glycemic control in adult and pediatric patients with diabetes mellitus requiring more than 200 units of insulin per day. This information was obtained from:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=b60e8dd0-1d48-4dc9-87fd-e14675255e8c

(2) Humulin NPH -- HUMULIN N is intermediate-acting recombinant human insulin indicated to improve glycemic control in adults and pediatric patients with diabetes mellitus. This information was obtained from:
The facility must:
1. Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
2. Store, prepare, distribute and serve food under sanitary conditions.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to store, prepare, and serve food in a sanitary manner.

The findings include:
On 8/16/16 at 11:50 a.m., an inspection of the facility kitchen was conducted. The following items were noted:

2 large plastic food prep/storage containers were observed wet nesting, along with 1 small prep/storage container on top of them, which was also wet.

In the oven, there was a large amount of black, burnt, crusty debris, piled approximately an inch to an inch and a half thick in height.

Next to a prep table that contained the toaster, there was a knife on the floor, and a can of soup on the floor.

The oven was cleaned and free from debris on 8-16-2016. The knife and can of soup was noted to be on the floor was picked up and put away appropriately on 8-16-2016. The dish machine was cleaned on 8-16-2016. The Jello in the refrigerator was stored with a vented cover was disposed of on 8-16-16.

2. A 100% audit will be completed by the Administrator or designee to ensure that the kitchen does not have any dishes wet-nesting, all containers are stored properly, dish machine is clean, oven is free from debris, and the floor does not have items left inappropriately.

3. The kitchen staff will be educated on proper cleaning of the stove and dish machine, proper storage of wet items, proper storing of refrigerated items, and picking up items that have fallen onto the floor by the Administrator, the Dietary Manager, or designee.
The dishwasher had brown crusty grime built up all around the edge of it on top, as well as brown crumbs spread out across the top.

In the refrigerator, a full size metal hotel pan containing orange jello had a plastic lid on top. The lid contained a rounded opening area along one edge of it for the storage of a long-handled serving spoon. This opening allowed for the jello to be exposed to the environment of the refrigerator and potential contamination.

In an interview with OSM #2 (Other Staff Member, the dietary manager), on 8/16/16 at 12:09 p.m., OSM #2 stated that the wet nesting dishes should have been air-dried first, before storing. OSM #2 stated that the soup can and knife should have been picked up at the time they were dropped. She stated that the oven is cleaned weekly, but should be cleaned more often if needed, and in this case cleaning was needed. OSM #2 stated that the dishwasher is also cleaned weekly but that it clearly had been much longer than that since anyone cleaned the top of it and the jello should have been stored in the refrigerator fully covered with saran wrap and dated. Policies regarding each of these concerns were requested from OSM #2 at this time.

A review of the facility policies that were provided revealed the following: The policy "Dish Washing Machine" documented, "...Allow all dishes and flatware to air dry before stacking. (DO NOT STACK WET DISHES)....Clean dishwashing area. Wipe clean walls and outside of the dish machine." The policy, "Cleaning Schedules" documented, "...Daily: Ranges/Stoves - at the end of each shift, clean grease traps and wipe off,

4. A weekly audit will be conducted for 3 months by the facility Administrator or designee. Audits will be brought to the facility quarterly quality assurance meeting.

5. Corrective action will be accomplished October 1, 2016.
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<td>F 371</td>
<td>Continued From page 131 inside and out.&quot;</td>
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On 8/18/16 at approximately 9:30 a.m., the Administrator was made aware of the findings. No other information or policies were provided by the end of the survey.

**F 372**  
483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY

The facility must dispose of garbage and refuse properly.

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, it was determined that the facility staff failed to maintain the dumpster area in a clean and sanitary manner to prevent pests.

The findings include:

On 8/17/16 at approximately 5:15 p.m., the inspection of the dumpster area was conducted with OSM #2 (Other Staff Member, Dietary Manager). There were 2 dumpster’s noted. He pointed out that 2 were used for general trash and 2 were used for dietary. Both dumpsters were observed to have the sliding side doors open all the way around. One dumpster was observed to have the top lid open. In addition, there were 4 individual pre-package cups of cream cheese and a used latex glove on the ground around the dumpster’s.

At this time, OSM #2 was asked about maintaining of the dumpsters. OSM #2 stated that the doors and lid should be closed at all

F 372 Dispose Garbage and Refuse Properly

1. The open lid on the dumpster was closed and trash that was on the ground was cleaned up properly on 8-17-16.

2. An initial audit will be completed on the dumpster area for proper disposal of garbage.

3. On 8-17-16 the facility Administrator updated the refuse contract to add an additional pick up day each week to prevent over full dumpsters.

4. Daily rounds (M-F) will be made for 3 months to ensure proper usage of the dumpster is maintained and that the facility refuse needs are being met with our current pick up days. Audit results will be presented at the facility quarterly quality assurance meeting.

5. Corrective Action will be accomplished on October 1, 2016.
F 372 Continued From page 132
times and that there should be no trash on the
ground around it. She stated that everyone is
responsible for keeping the area clean but that
dietary had the main responsibility. At this time a
request was made for the facility’s policy on
maintaining the dumpster area. On 8/18/16 at
approximately 8:15 a.m., OSM #2 stated there
were no policies regarding the dumpster.

On 8/18/16 at approximately 9:30 a.m., the
Administrator was made aware of the findings.
No other information or policies were provided by
the end of the survey.

F 431 SS=D
483.60(b), (d), (e) DRUG RECORDS,
LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of
a licensed pharmacist who establishes a system
of records of receipt and disposition of all
controlled drugs in sufficient detail to enable an
accurate reconciliation; and determines that drug
records are in order and that an account of all
controlled drugs is maintained and periodically
reconciled.

Drugs and biologicals used in the facility must be
labeled in accordance with currently accepted
professional principles, and include the
appropriate accessory and cautionary
instructions, and the expiration date when
applicable.

In accordance with State and Federal laws, the
facility must store all drugs and biologicals in
locked compartments under proper temperature
controls, and permit only authorized personnel to
have access to the keys.

F 431

1. The unmarked vial identified in the
South Wing Medication Room with no
date or initials was discarded.

2. A 100% audit of both medication
rooms will be completed to ensure
compliance of proper dating and
initialing of opened medications.
The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, it was determined that facility staff failed to label medications in one of two medication rooms, the South Wing medication room.

Facility staff failed to label an opened vial of Novolog located in the South Wing’s medication refrigerator.

The findings include:

An observation was made on 8/17/16 at 3:20 p.m. of the South Wing medication room with LPN (licensed practical nurse) #7. In the refrigerator were several plastic brown medicine bottles with medication vials inside. Several bottles were checked and then one full vial of Novolog insulin that was observed to be open was checked. LPN #7 was asked to look for the open date of the Novolog insulin. LPN #7 stated, “There’s no date on it so it needs to be discarded now. To me it is outdated now,” LPN #7 took the vial and discarded it. When asked how long an opened vial of Novolog insulin could be used, LPN #7...
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<td>F 431</td>
<td>Continued From page 134 stated, &quot;28 days.” On 8/17/16 at 3:25 p.m. LPN #3, the unit manager stated that they were always checking on the medications. On 8/17/16 at 5:45 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. &quot;NovoLog: Package Insert and Label Information. 16.2 Recommended Storage: … Vials: After initial use a vial may be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or light. Opened vials may be refrigerated.&quot; This information was obtained from the website: <a href="http://druginserts.com/lib/rx/meds/novolog/page/4">http://druginserts.com/lib/rx/meds/novolog/page/4</a></td>
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<td>F 441</td>
<td>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it: (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,</td>
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should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility policy review and clinical record review, it was determined that the facility staff failed to follow infection control practices on one of 25 residents in the survey sample, Resident #16.

1. a. For Resident #16, facility staff failed to wipe off the insulin bottles with alcohol prior to withdrawing insulin from the vials during the medication administration administration observation on 8/17/16 at 8:12 a.m.

2. All professional nursing staff (RN's and LPN's) will be educated on medication pass standards and on infection control practice. This education will be provided by the Pharmacy. Each nurse will be observed during a medication pass for compliance with standards and competency.

3. New hire RN's and LPN's will be educated on medication pass standards during their orientation process. New hire RN's and LPN's will be observed during a medication pass for compliance with standards and competency.

4. Medication pass observation audits will be done weekly times one month by the DON, ADON, UMs, or designee. Then, biweekly times one month. Results of audits will be presented at the facility's Quarterly Quality Assurance Meeting.

5. Corrective action will be completed October 1, 2016.
Continued From page 136

1. b. Facility staff failed to sanitize the eye drop bottles that had been placed on Resident #16's table and the inhaler that had been held by the resident prior to returning the medication into the medication cart during the medication administration observation on 8/17/16 at 8:12 a.m.

The findings include:

1 a. For Resident #16, facility staff failed to wipe off the insulin bottles with alcohol prior to withdrawing insulin from the vials during the medication administration observation on 8/17/16 at 8:12 a.m.

Resident #16 was admitted to the facility on 7/31/08 and readmitted on 9/5/14 with diagnoses that included but were not limited to: dementia, diabetes, obesity and arthritis.

The most recent MDS, a quarterly assessment with an ARD of 6/1/16 coded the resident as having a 13 out of 50 on the BIMS indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from one staff member for activities of daily living.

An observation of the medication administration was conducted on 8/17/16 at 8:12 a.m. with RN #3. RN #3 took an insulin syringe out of the medication cart and then took two vials of insulin out of the cart. RN #3 then inserted the insulin syringe needle into the first insulin vial without wiping off the top of the vial with alcohol and
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**BROOKSIDE REHAB & NURSING CENTER**

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| F 441   |             | continued from page 137 withdrew the insulin. RN #3 withdrew the needle from the vial and inserted the insulin syringe needle into the second bottle of insulin without wiping off the top of the vial. After withdrawing the insulin, RN #3 took the needle out of the vial. An interview was conducted on 8/17/16 at 10:50 a.m. with LPN #3, the unit manager. When asked the process for drawing up insulin, LPN #3 stated, "Pull the vial out for the proper resident, check that it's the correct insulin with the correct patient. Open up an alcohol wipe and wipe off the top." When asked why staff would wipe off the vial with alcohol, LPN #3 stated it was for infection control purposes.

An interview was conducted on 8/17/16 at 10:55 a.m. with RN #3. When asked if the insulin vials should be wipe off with alcohol before withdrawing the insulin, RN #3 stated that it should and that she had not done that. "Giving an insulin injection: If the insulin vial has a plastic cover, take it off. Wipe the top of the bottle with an alcohol wipe. Let it dry. DO NOT blow on it." This information was obtained from the website: <https://medlineplus.gov/healthtopics.html>

On 8/17/16 at 5:49 p.m. ASM #2, the director of nursing was made aware of the findings.

1 b. Facility staff failed to sanitize the eye drop bottles that had been placed on Resident #16's table and the inhaler that had been held by the resident prior to returning the medication into the medication cart during the medication administration observation on 8/17/16 at 8:12
Continued From page 138 a.m.

An observation of the medication administration was conducted on 8/17/16 at 8:12 a.m. with RN #3. RN #3 took three eye drop bottles and one inhaler out of the medication cart. RN #3 left the eye drop bottles contained in brown prescription bottles, and took the inhaler out of the box. RN #3 then locked the medication cart and took the medications into Resident #16’s room. RN #3 then placed the eye drop bottles on the resident’s bedside table that had three plastic cups, a banana peel and other items and handed the inhaler to the resident. After the resident used the inhaler, RN #3 then administered the eye drops to Resident #16. RN #3 then placed the eye drop bottles and inhaler back into the medication cart without wiping them off.

An interview was conducted on 8/17/16 at 10:50 a.m. with LPN #3. When asked what process staff followed when replacing medications that had been on a resident’s table or held by the resident, LPN #3 stated, “You have to wipe them down.” When asked why, LPN #3 stated that it was for infection control purpose.

An interview was conducted on 8/17/16 with RN #3. When asked what process staff followed when replacing medications that had been on a resident’s table or held by the resident, RN #3 stated she should have wiped them off prior to returning them to the cart. When asked why RN #3 stated for infection control.

On 8/17/16 at 7:50 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.
**Summary Statement of Deficiencies**

**ID** 441  
**Provider/Supplemental Information:** Continued From page 139

Review of the facility's policy titled, "General Dose Preparation and Medication Administration" documented, "Procedure: 4. Prior to administration of medication, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: 4.2.1 Clean work surface prior to use. 6. After medication administration Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: 6.4 Clean any reusable equipment or supplies."

No further information was provided prior to exit.

**ID** 502  
**Prefix** SS  
**Tag** E  
**Provider/Supplemental Information:** 483.75(j)(1) ADMINISTRATION

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:
- Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to obtain physician ordered laboratory tests for four of 25 residents in the survey sample, Residents #3, #21, #16 and #15.

1. The facility failed to obtain a physician ordered laboratory tests, liver function test (1) and lipid panel test (2) for Resident #3.

2. The facility failed to obtain a physician ordered laboratory tests, CBC [complete blood count (1)].

**F502: Administration**

1) For resident #3, a liver function test was drawn on 7/5/16 and a Lipid Panel was drawn on 8/23/16. For resident #21, a BMP and a CBC were drawn on 8/20/16, and a Lipid Panel on 9/6/16. For resident #16, a TSH was drawn on 3/9/16, not in Feb. when it was ordered. The prior year, the TSH was also drawn in March. Therefore resident did have the lab work annually. For resident #15, labs were drawn 9/6/16.

2) A 100% audit will be done on all residents POS’S to determine if a specific month was designated.

An audit of 100% of current POS’S to ensure that labs scheduled for this month are on the audit tool, and lab slips in the book.
F 502 Continued From page 140

BMP [basic metabolic panel (2)] lipid panel test (3) for Resident # 21.

3. The facility staff failed to obtain Resident #16's TSH (thyroid stimulating hormone) level in February 2016 per physician's order.

4. The facility staff failed to obtain the physician ordered laboratory tests in January and July 2016 for Resident #15.

The findings include:

1. The facility failed to obtain a physician ordered laboratory tests, liver function test (1) and lipid panel test (2) for Resident # 3.

Resident # 3 was admitted to the facility on 6/19/15 with diagnoses that included but were not limited to: benign prostatic hyperplasia (3), low iron, hypothyroidism (4), and lymphocytopenia (5).

Resident # 3's most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/22/16, coded Resident # 3 as scoring a 10 (ten) on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 (ten) - being moderately impaired of cognition for making daily decisions. Resident # 3 was coded as being independent for activities of daily living.

The "Physician's Order Sheet" for Resident # 3 dated 08/01/16 through 08/31/16 and signed by the physician on 8/3/16 documented, "Liver / Lipid Panel every 6 (six) months (Jan - July) [January-July]." 4

3) Standing orders for labs based on medications being administrated, will be modified to a specific time frame only and not to a specific designated month. On change over, nurse will identify what labs need to be drawn that particular month. She will document on the audit tool in the nursing station. She will also make a list for the nursing supervisor so she can make out the lab slips and put them in the lab book.

4) The unit secretaries or designee will do weekly audits x 4 weeks and then biweekly x 4 weeks, to be sure the labs were drawn and the results are on the charts. The results of these audits will be reported at the Quarterly Quality Assurance meeting.

5) Corrective action will be completed October 1, 2016.
**F 502** Continued From page 141

Review of the clinical record for Resident # 3 failed to evidence the physician ordered laboratory test results for the liver function and a lipid panel.

On 8/17/16 at 12:05 p.m. an interview was conducted with the unit secretary, CNA (certified nursing assistant) # 1 regarding the laboratory test results for Resident # 3. CNA # 1 stated, "The labs were not done."

On 8/18/16 at 7:55 a.m. an interview was conducted with LPN (licensed practical nurse) # 3, unit manager regarding the missing laboratory tests for Resident # 3. LPN # 3 stated that they had identified a problem with obtaining laboratory tests for the residents. LPN # 3 provided a copy of a document entitled "Lab issues" dated 6/2016. When asked about the document LPN # 3 stated, "I came up with the plan because I identified the problem with obtaining labs (laboratory tests). We are currently doing an audit of charts and still working on it. The plan was approved by (Name of the Administrator) and (Name of the director of nursing)."

On 8/17/16 at 5:20 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above findings.

No further information was presented prior to exit.

On 8/18/16 at 8:10 a.m. an interview was conducted with ASM (administrative staff member) # 1 the administrator and ASM # 2, the director of nursing regarding the issue of obtaining laboratory tests. ASM # 2 stated that the previous laboratory company the facility was
F 502 Continued From page 142

using "Shut their doors about two to three months ago and we were never notified it had closed. We're in the process of using a different lab for services and we're planning on a complete overhaul of lab services."

The Facility's policy "Lab and Diagnostic Test Results - Clinical Protocol" documented, "Assessment and Recognition: 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility."

References:

(1) Liver function tests are common tests that are used to see how well the liver is working. This information was obtained from the website: https://medlineplus.gov/ency/article/003436.htm.

(2) Test for Cholesterol. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000386.htm.

(3) Used to treat dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and may cause changes in mood and personality) in people who have Alzheimer's disease (AD; a brain disease that slowly destroys the memory and the ability to think, learn, communicate and handle daily activities). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697032.htm.

(4) An enlarged prostate. This information was
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<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory Or LSC Identifying Information)</th>
<th>ID tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>F 502</td>
<td>Continued From page 143 obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html">https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html</a>.</td>
<td>F 502</td>
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<tr>
<td></td>
<td>(5) Not enough thyroid hormone to meet your body's needs. This information was obtained from the website:</td>
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<tr>
<td></td>
<td>2. The facility failed to obtain a physician ordered laboratory tests, CBC [complete blood count (1)],</td>
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<tr>
<td></td>
<td>BMP [basic metabolic panel (2)], lipid panel test (3) for Resident # 21.</td>
<td></td>
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<tr>
<td></td>
<td>Resident # 21 was admitted to the facility on 7/19/15 with diagnoses that included but were not limited to:</td>
<td></td>
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<tr>
<td></td>
<td>atrial fibrillation (4), low iron, hypothyroidism (4), diabetes mellitus (5),</td>
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<tr>
<td></td>
<td>hypertension (6) dysphagia (7), and a fractured right femur neck (8).</td>
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<tr>
<td></td>
<td>Resident # 21's most recent comprehensive MDS (minimum data set), an admission assessment with an ARD</td>
<td></td>
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<tr>
<td></td>
<td>(assessment reference date) of 7/27/16, coded Resident # 21 as scoring a 7 (seven) on the brief interview</td>
<td></td>
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<tr>
<td></td>
<td>for mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely impaired of cognition for</td>
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<td></td>
<td>making daily decisions. Resident # 21 was coded as requiring limited assistance of one staff member for</td>
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<td></td>
<td>activities of daily living.</td>
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<tr>
<td></td>
<td>The &quot;Physician's Order Sheet&quot; for Resident # 21 dated 07/20/16 through 07/31/16 and signed by the</td>
<td></td>
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<tr>
<td></td>
<td>physician on 07/21/16 documented, &quot;Lipid Panel every 6 (six) months.&quot;</td>
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</tbody>
</table>
F 502 Continued From page 144

The "Physician's Telephone Order" for Resident # 21 dated 7/21/16 documented in part, "CBC (complete blood count), BMP (basic metabolic panel)."

Review of the clinical record for Resident # 21 failed to evidence the physician ordered laboratory test results for the lipid panel, CBC and BMP.

On 8/17/16 at 3:40 p.m, an interview was conducted with the unit secretary, CNA (certified nursing assistant) # 1 and RN (registered nurse) # 1, assistant director of nursing regarding the laboratory test results for Resident # 21. CNA # 1 stated, "The labs were not done."

On 8/17/16 at 5:20 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing were made aware of the above findings.

No further information was presented prior to exit.

References:

(1) A comprehensive metabolic panel is a group of blood tests. They provide an overall picture of your body's chemical balance and metabolism. This information was obtained from the website: <https://medlineplus.gov/ency/article/003468.htm>.

(2) The basic metabolic panel is a group of blood tests that provides information about your body's metabolism. This information was obtained from the website: <https://medlineplus.gov/ency/article/003462.htm>.
(3) Test for Cholesterol. This information was obtained from the website: <https://medlineplus.gov/ency/patientinstructions/000386.htm>.

(4) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

(5) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(6) High blood pressure. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/highbloodpressure.html>.

(7) A swallowing disorder. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html>.

(8) Femur, also called the thigh bone, in your leg. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/00166.htm.

3. The facility staff failed to obtain Resident #16’s TSH (thyroid stimulating hormone (1)) level in February 2016 per physician’s order.
F 502 Continued From page 146

Resident #16 was admitted to the facility on 7/31/08. The resident's diagnoses included but were not limited to: hypothyroidism (2), diabetes and asthma. Resident #16's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/1/16, coded the resident as being cognitively intact.

Review of Resident #16's clinical record revealed a physician's order summary signed by the physician on 1/7/16 that documented a physician's order for a TSH every February. The resident's February 2016 TAR (treatment administration record) documented, "TSH EVERY FEBRUARY." Further review of Resident #16's clinical record failed to reveal a TSH was obtained in February 2016 as ordered. A TSH was obtained on 3/9/16.

Resident #16's comprehensive care plan initiated on 9/18/14 documented, "Resident at risk for hypo/hyperthyroidism. Resident with dx. (diagnosis) of hypothyroidism...interventions: Labs (laboratory tests) per orders..."

On 8/17/16 at 4:15 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated the facility had been having issues with obtaining labs and receiving lab results. LPN #3 stated scheduled labs are documented on a calendar and each resident's TAR (treatment administration record). LPN #3 stated the facility staff had also recently implemented a lab book to track labs. LPN #3 stated their contracted laboratory had recently closed an office and didn't notify the facility. LPN #3 stated the lab had changed the times the facility received phlebotomy services. LPN #3 stated a phlebotomist from the lab draws Resident #16's
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LBC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 502</td>
<td></td>
<td></td>
<td>Continued From page 147 blood. LPN #3 was asked to find out if a TSH had been obtained from Resident #16 in February 2016 per physician's order. On 8/17/16 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. On 8/18/16 at 7:55 a.m., LPN #3 stated she had no further information regarding the TSH level that was due for Resident #16 in February 2016. LPN #3 stated she had designed a plan of correction regarding labs because facility staff knew there were issues. LPN #3 stated the unit secretary was completing a lab audit and the plan was still in progress. No further information was presented prior to exit. (1) The TSH (thyroid stimulating hormone) level is a blood test used to check thyroid function. This information was obtained from: <a href="https://www.niddk.nih.gov/health-information/health-topics/diagnostic-tests/thyroid-tests/Pages/default.aspx">https://www.niddk.nih.gov/health-information/health-topics/diagnostic-tests/thyroid-tests/Pages/default.aspx</a> (2) &quot;Your thyroid is a butterfly-shaped gland in your neck, just above your collarbone. It is one of your endocrine glands, which make hormones. Thyroid hormones control the rate of many activities in your body. These include how fast you burn calories and how fast your heart beats. All of these activities are your body's metabolism. If your thyroid gland is not active enough, it does not make enough thyroid hormone to meet your body's needs. This condition is hypothyroidism.&quot; This information was obtained from the website: <a href="https://medlineplus.gov/hypothyroidism.html">https://medlineplus.gov/hypothyroidism.html</a></td>
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</tbody>
</table>

FORM CMS-2587(02-99) Previous Versions Obsolete Event ID: FV2R11 Facility ID: VA0176 If continuation sheet Page 148 of 164
4. Facility staff failed to obtain the physician ordered laboratory tests in January and July 2016 for Resident #15.

Resident #15 was admitted to the facility on 7/1/14 with diagnoses that included but were not limited to: difficulty swallowing, elevated cholesterol, diabetes and depression.

The most recent MDS, an annual assessment, with an ARD of 6/29/16 coded the resident as having an 11 cut 15 on the BIMS indicating the resident was moderately impaired cognitively to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the physician's orders dated and signed on 7/29/16 documented, "HBG (hemoglobin) A1C (1) EVERY THREE MONTHS (JAN (January)/APRIL/JULY/OCT (October))."

Review of the Resident #15's physician standing orders, not dated, documented, "Labs (laboratory tests): If receiving medication, please follow the parameters for lab monitoring as established below: BMP (basic metabolic panel (2)), antihypertensive/ ACEI (angiotensin-converting enzyme (ACE) inhibitors (3)) / ARB (angiotensin II receptor blockers (4)) / diuretics (5)...upon admission and....every 6 months."

Review of the physician's orders dated and
**NAME OF PROVIDER OR SUPPLIER**

BROOKSIDE REHAB & NURSING CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

614 HASTINGS LANE

WARRENTON, VA 20186

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<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 502</td>
<td>Continued From page 149 signed 7/29/16, documented, &quot;FUROSEMIDE (6) 40MG (milligrams) TABLET FOR&gt; LASIX (7) TAKE 1 TAB (tablet) BY MOUTH EVERY MORNING FOR GENERAL EDEMA.&quot; Review of the care plan initiated on 7/16/14 and revised on 7/12/16, documented, &quot;Focus. Resident at risk for altered cardiac output due to dx (diagnoses), of HTN (hypertension), and HLD (hyperlipids). Interventions. Labs per orders. Focus. Resident at risk for hypo/hyperglycemia (high or low blood sugar). Resident with dx of DM. Interventions. Labs per orders.&quot; Review of Resident #15's laboratory results did not evidence documentation for the January 2016 BMP results or the July 2016 BMP and HBG A1C results. An interview was conducted on 8/17/16 at 4:15 p.m. with LPN (licensed practical nurse) #3, the unit manager. When a copy of the January and July 2016 BMP and the July HBG A1C results were requested, LPN #3 stated, &quot;This is our issue with the lab. We aren't getting the results. When we changed to (name of facility) the lab kept faxing (laboratory results) to (name of previous facility name) so we don't know where they're going.&quot; When asked the process staff used to track laboratory results, LPN #3 stated, &quot;We put a yellow slip in the chart (carbon copy of the laboratory's slip) as proof that it was drawn, but we didn't have a system to go back and make sure we had the results.&quot; When asked what the purpose was for the laboratory tests, LPN #3 stated, &quot;Because they're medication monitoring (tools) and also to see if something is going on (with the resident).&quot; When asked how the physician received the results, LPN #3 stated,</td>
<td>F 502</td>
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*RECEIVED*

SEP 12 2016

VDH/OLC
F 502 Continued From page 150

"We fax the results to the doctor or if he's coming in and it's not critical we can leave it in his box for the next morning." LPN #3 stated they would look for the laboratory results.

On 8/17/16 at 5:49 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

An interview was conducted on 8/18/16 at 8:02 a.m., with LPN #3 and CNA (certified nursing assistant and unit secretary) #1. LPN #3 stated that could not locate the January and July BMP results or the July HGB A1C results. LPN #3 stated, "She (Resident #15) had a HGB A1C in June and the tech (technician) should have called him (the doctor) to see if he wanted another one. It should have been done." LPN #3 then stated, "We have developed a plan to correct this. We are doing a lab audit now." CNA #1 stated, "I keep all the yellow lab slip in a notebook and when the results come back I match it to the yellow slip." CNA #1 stated that if the result was not received she would follow up with the laboratory company.

No further information was provided prior to exit.

(1) The A1C test is a blood test that provides information about a person’s average levels of blood glucose, also called blood sugar, over the past 3 months. The A1C test is sometimes called the hemoglobin A1c, HbA1c, or glycohemoglobin test. The A1C test is the primary test used for diabetes management and diabetes research. This information was obtained from: https://www.niddk.nih.gov/health-information/diabetes-diabetes-prediabetes/a1c-test
Continued From page 151

(2) BMP -- A metabolic panel is a group of tests that measures different chemicals in the blood. These tests are usually done on the fluid (plasma) part of blood. The tests provide information about your body's chemical balance and metabolism. They can give doctors information about your muscles (including the heart), bones, and organs, such as the kidneys and liver. This information was obtained from: https://medlineplus.gov/metabolicpanel.html

(3) ACEI -- The angiotensin-converting enzyme (ACE) inhibitors are a widely used class of antihypertensive medications that act by blocking the conversion of angiotensin I to angiotensin II, thus inhibiting an intermediate step in the renin-angiotensin pathway. The ACE inhibitors are rare causes of clinically apparent liver injury. This information was obtained from: http://livertox.nih.gov/Angiotensin-Converting_Engzyme_Inhibitors.htm

(4) ARB -- The angiotensin II receptor blockers (ARBs) represent a newer class of antihypertensive agents. Their mechanism of action differs from that of the angiotensin-converting enzyme (ACE) inhibitors, which also affect the renin-angiotensin system. This information was obtained from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1200815/

(5) Diuretics -- Diuretics constitute a large family of medications that increase urine flow and induce urinary sodium loss and are widely used for therapy of hypertension, congestive heart failure, and edematous states. This information was obtained from: http://livertox.nih.gov/Diuretics.htm

(6) Furosemide -- Furosemide is a potent diuretic which, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte...
F 502

Continued From page 152

depletion. This information was obtained from:
(7) Lasix -- LASIX® (furosemide) is a potent diuretic which, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte depletion. This information was
obtained from:

F 504

483.75(1)(2)(i) LAB SVCS ONLY WHEN
ORDERED BY PHYSICIAN

The facility must provide or obtain laboratory services only when ordered by the attending physician.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to obtain a physician's order for a laboratory test for one of 25 residents in the survey sample, Resident #16.

The facility staff failed to obtain a physician's order for a TSH (thyroid stimulating hormone (1)) level obtained from Resident #16 on 3/9/16.

The findings include:

Resident #16 was admitted to the facility on 7/31/08. The resident's diagnoses included but were not limited to: hypothyroidism (2), diabetes and asthma. Resident #16's most recent MDS

F 504: LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN

1) For resident #16, TSH was done on 3/9/2016, when lab was ordered in FEB. Lab was also drawn in March of 2015, so it was done annually.

2) A 100% audit will be done on all residents POS'S to determine if a specific month was designated.

An audit of 100% of current POS'S to ensure that labs scheduled for this month are on the audit tool, and lab slips in the book.
3) Standing orders for labs based on medications being administered, will be modified to a specific time frame only and not to a specific designated month.

On change over, nurse will identify what labs need to be drawn that particular month. She will document on the audit tool in the nursing station. She will also make a list for the nursing supervisor so she can make out the lab slips and put them in the lab book.

4) The unit secretaries or designee will do weekly audits x 4 weeks and then bi-weekly x 4 weeks, to be sure the labs were drawn and the results are on the charts. The results of these audits will be reported at the Quarterly Quality Assurance meeting.

5) Corrective action will be completed October 1, 2016.
Continued From page 154

usually says to obtain the labs when they can. LPN #3 was asked to provide documentation that the physician was notified regarding Resident #16's missed TSH in February and physician's order to obtain the missing lab on 3/8/16.

On 8/17/16 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

On 8/18/16 at 7:55 a.m., LPN #3 stated she had no further information regarding the TSH level obtained from Resident #16 on 3/9/16. LPN #3 stated she had designed a plan of correction regarding labs because facility staff knew there were issues. LPN #3 stated the unit secretary was completing a lab audit and the plan was still in progress.

The facility policy titled, "Lab and Diagnostic Tests Results- Clinical Protocol" documented in part, "Assessment and Recognition- 1. The physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility..."

No further information was presented prior to exit.

(1) The TSH (thyroid stimulating hormone) level is a blood test used to check thyroid function. This information was obtained from:
https://www.niddk.nih.gov/health-information/health-topics/diagnostic-tests/thyroid-tests/Pages/default.aspx
Continued From page 155

(2) "Your thyroid is a butterfly-shaped gland in your neck, just above your collarbone. It is one of your endocrine glands, which make hormones. Thyroid hormones control the rate of many activities in your body. These include how fast you burn calories and how fast your heart beats. All of these activities are your body's metabolism. If your thyroid gland is not active enough, it does not make enough thyroid hormone to meet your body's needs. This condition is hypothyroidism." This information was obtained from the website: https://medlineplus.gov/hypothyroidism.html

F 514

483.75(I)(1) RES

RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for two of 25 residents in the survey sample, Residents #4 and #5.

F 514

1. The obtained order for Tylenol for resident #4 on 7/16/16 cannot be corrected. The MD has been notified at this time. The blanks on the May and June 2016 MAR cannot be corrected for resident #5; a clinical incident was completed.

2. An initial audit of all current MARS will be completed by the DON, ADON, UMs, or designee.
<table>
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<tr>
<th>Statement of Deficiencies and Plan of Correction</th>
<th>Providers Plan of Correction</th>
<th>Date Survey Completed</th>
</tr>
</thead>
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<td>(X1) Provider/Suppliers/CLIA Identification Number: 495267</td>
<td>(X2) Multiple Construction</td>
<td>(X3) Date Survey Completed: C 08/18/2016</td>
</tr>
</tbody>
</table>

**Name of Provider or Supplier:**

Brookside Rehab & Nursing Center

**Address:**

614 Hastings Lane

Warrenton, VA 20186

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**F 514**

Continued from page 156

1. The facility staff failed to document information regarding why a physician's order for Tylenol was obtained for Resident #4 on 7/16/16.

2. Facility staff failed to document the administration of medications on several occasions during the months of May and June of 2016 for Resident #5.

The findings include:

1. The facility staff failed to document information regarding why a physician's order for Tylenol (used to relieve mild to moderate pain (1)) was obtained for Resident #4 on 7/16/16.

Resident #4 was admitted to the facility on 9/27/11. Resident #4's diagnoses included but were not limited to: dementia (2), osteoarthritis (3) and gout (4). Resident #4's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 7/3/16, coded the resident's cognition as severely impaired. Section J documented Resident #4 had not voiced any complaints of pain during the five day look back period.

Review of Resident #4's clinical record revealed a physician's order dated 7/16/16 that documented, "Tylenol 650 mg (milligrams) po (by mouth) q (every) 4 (hours) PRN (as needed) for discomfort x (times) 48 (hours) then notify md (medical doctor)." Resident #4's July 2016 MAR (medication administration record) revealed the resident was administered Tylenol 650 mg on 7/16/16 at 2:30 p.m. for a complaint of "I'm sick," Further review of Resident #4's clinical record failed to reveal documentation of what event prompted the nurse to obtain the Tylenol order.

3. The nursing professionals (LPN's and RN's) will be educated on following standing order protocol and discontinuing medications after stated time frame and documentation standards. The nursing staff (RN's and LPN's) for standing orders will block off the time that medication can be administered and yellow out when the medication administration time has lapsed. If it is felt that a resident needs more medication a request will be made to the MD for an order.

4. A 100% audit of MARS for standing order use will be completed weekly for one month, then biweekly for one month. Audit results will be presented at the facility's Quarterly Quality Assurance Committee.

5. Correction action will be completed October 1, 2016.
F 514
Continued From page 157
No nurse’s note for 7/16/16 was present.

Resident #4’s comprehensive care plan revised on 7/12/15 documented, "The resident has Arthritis/ She is at risk for pain...Interventions: Monitor/document/report to MD PRN s/sx (signs and symptoms) or complications related to arthritis: Joint pain, Joint stiffness, usually worse on wakening, Swelling, Decline in mobility, Decline in self care ability, Contracture formation/joint shape changes, Crepitis (creaking or clicking with joint movement), pain after exercise or weight bearing..."

The nurse responsible for obtaining the Tylenol order on 7/16/16 was not available for interview.

On 8/17/16 at 7:35 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was shown the above physician’s order. LPN #4 was asked what should be documented in the clinical record when a nurse obtains a new order. LPN #4 stated, "Normally when you get an order, you write a note 'new order received' and the reasoning for it." LPN #4 confirmed there was no documentation in Resident #4’s nurses’ notes for 7/16/16. LPN #4 stated, "She probably should have wrote a note but it’s just Tylenol. Our people get aches and pains all the time."

On 8/17/16 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

On 8/18/16 at 7:55 a.m., an interview was conducted with LPN #3. LPN #3 was shown the above Tylenol order. LPN #3 was asked what should be documented in the clinical record. LPN
F 514 Continued From page 158

#3 stated, "Vital signs; any signs or symptoms of pain or the reasoning behind it (the order); if the Tylenol was effective and notify the doctor with the findings."

The facility policy titled, "Charting and Documentation" documented in part, "All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record..."

No further information was presented prior to exit.

(1) This information was obtained from the website:
https://medlineplus.gov/druginfo/meds/a681004.html

(2) "Dementia is not a specific disease. It is a descriptive term for a collection of symptoms that can be caused by a number of disorders that affect the brain. People with dementia have significantly impaired intellectual functioning that interferes with normal activities and relationships. They also lose their ability to solve problems and maintain emotional control, and they may experience personality changes and behavioral problems, such as agitation, delusions, and hallucinations..." This information was obtained from the website:
http://www.ninds.nih.gov/disorders/dementias/dementia.htm

(3) "Osteoarthritis is the most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine." This information was obtained from the website:
https://medlineplus.gov/osteoarthritis.html
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
BROOKSIDE REHAB & NURSING CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
614 HASTINGS LANE
WARRENTON, VA 20186

(4) "Gout is a common, painful form of arthritis. It causes swollen, red, hot and stiff joints." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=gout&_ga=1.208445906.1308579129.1468338746

2. The facility staff failed to document the administration of medications on several occasions during the months of May and June of 2016 for Resident #5.

Resident #5 was admitted to the facility on 4/7/16 with diagnoses that included but were not limited to recurrent sarcoma cancer, enlarged prostate with the use of a catheter, stroke, high cholesterol, dementia, anxiety, heart disease, chronic kidney disease, and hemiplegia (paralysis) to one side of the body.

Resident #5's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/13/16. Resident #5 was coded as being severely impaired in cognitive status scoring three out of 15 on the BIMS (brief interview for mental status) exam. Resident #5 was coded as requiring supervision to limited assistance with ADLS (activities of daily living).

Review of Resident #5's May and June 2016 MARs (Medication Administration Record) revealed blanks (no signatures) for the following medications, dates, and times:
F 514 Continued From page 160

(1) Coreg 3.125 mg (milligrams) tablet on 5/25/16 at 5:00 p.m.,
6/8/16 at 9:00 a.m., 6/30/16 at 9:00 a.m.
(2) Depakote Sprinkle 125 mg on 5/25/16 at p.m.,
6/8/16 at 9:00 a.m., 6/30/16 at 9:00 a.m.
(3) Colace softgel 100 mg on 5/25/16 at 5 p.m.,
6/8/16 at 9:00 a.m., 6/30/16 at 9:00 a.m.
(4) Ibuprofen 600 mg tablet TID (three times a
day) on 6/26/16 at 9:00 a.m. and 5 p.m.
(5) Proscar 5 mg tablet on 6/8/16 at 9:00 a.m.,
6/30/16 at 9:00 a.m.
(6) Cozaar 50 mg tablet on 6/8/16 at 9:00 a.m.,
6/30/16 at 9:00 a.m.
(7) Flomax 0.4 mg tablet on 6/30/16 at 9:00 a.m.

Review of the clinical record revealed no nursing notes documenting why there were blanks (no signatures) on the MAR.

On 8/17/16 at 3:18 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #3, the unit manager. When asked what holes (blanks) meant on the MARS, she stated that the medication was not signed off. She stated that she could not say that the medications were not given. She stated that the nurses who worked the above shifts probably forgot to sign off the medications. When asked how the facility ensures that there are no blanks on the MARS, she stated that she will spot check herself and the nurses into the facility if they forgot to sign. She stated that the nurses should also be checking over the MARS at the end of each shift to ensure that all medications or treatments are signed off. LPN #3 could not make out the signatures of the nurses who worked the above shifts. She stated that she RN (Registered
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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 514</td>
<td>Continued From page 161 Nurse) #3 may have worked one of those days. On 8/18/16 at approximately 9:00 a.m., an interview was conducted with RN (Registered Nurse) #3. When asked what blanks meant on the MAR, she stated that a nurse may have given the medications but forgot to sign off on the MAR. She stated that nurses should always double check the MARS at the end of the shift. She confirmed that she did not work the shifts that were missing the signatures on the MAR and she could not identify who worked that day. The nurses who worked the above shifts could not be reached for an interview. On 8/18/16 at 10:15 a.m., ASM (Administrative Staff Member) #1, the DON (Director of Nursing) was made aware of the above concerns. Facility policy titled, &quot;Documentation of Medication Administration,&quot; documented in part, the following: &quot;1. Nurse or Certified Medication Aide (where applicable) shall document all medications administered to each resident on the resident's medication administration record (MAR). 2. Administration of medication must be documented immediately after (never before) it is given. 3. Documentation must include, as a minimum: ...f. Signature and title of person administering the medication.&quot; No further information was presented prior to exit. (1) Coreg is used to alone or in combination with other medications to treat high blood pressure. This information was obtained from The National Institutes of Health.</td>
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2. Depakote is an anti-convulsant used to treat seizure disorder. This information was obtained from The National Institutes of Health.


3. Colace is used as a stool softener that relieves occasional constipation, generally producing a bowel movement in 6-12 hours. This information was obtained from The National Institutes of Health.


4. Ibuprofen is a non-steroid anti-inflammatory agent with analgesic properties used for therapy associated with conditions such as arthritis. This information was obtained from The National Institutes of Health.


5. Proscar is used to relieve symptoms in men with an enlarged prostate and to reduce the risk of urinary retention. This information was obtained from The National Institutes of Health.

> https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=7c01f541-1c88-400c-41a9-7cbb9dee50c0.

6. Cozaar is used to treat high blood pressure, reduce the risk of stroke in patients with high blood pressure and an enlarged heart, and treats kidney disease in patients with diabetes. This information was obtained from The National Institutes of Health.


7. Flomax is used to treat men with symptoms of an enlarged prostate. This information was
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