STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495262	A. BUILDING ______ B. WING ______	01/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH NURSING HOME	339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/17/17 through 1/18/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 60 certified bed facility was 56 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents 1 through 12) and 2 closed record review (Residents 13 through 14).	F 000		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.	F 225		2/3/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/27/2017

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

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F 225	Continued From page 1 (4) Report to the State nurse aide registry or licensing authorities 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. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and	F 225		

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F 225	Continued From page 2 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, the facility staff failed to report and investigate allegations of abuse/neglect for two of 14 residents in the survey sample. The facility failed to thoroughly investigate and report to the state agency a report from adult protective services (APS) alleging the facility over-medicated Resident #13 resulting in dehydration. A report from APS that Resident #9 was rough handled during her shower and personal care was not thoroughly investigated or reported to the state agency. The findings include: 1. The facility failed to thoroughly investigate and report to the state agency a report from APS alleging the facility over-medicated Resident #13 resulting in dehydration. Resident #13 was admitted to the facility on 12/13/16, re-admitted on 1/4/17 and died in the facility on 1/11/17. Diagnoses for Resident #13 included cancer, chronic kidney disease, failure to thrive, atrial fibrillation and urinary tract infection. The minimum data set (MDS) dated 1/10/17 assessed Resident #13 with short and long-term memory problems and severely impaired cognitive skills. An adult protective services intake report dated 12/30/16 documented an anonymous allegation of neglect by the facility regarding care provided for Resident #13. The report alleged the resident was hospitalized with severe dehydration due to	F 225	1.) Investigation completed on Resident # 13 and Resident #9 at the time APS made facility aware of the allegation of abuse. Facility wrote up formal investigation and submitted a late report to the state agency on 1/25/2017. 2.) Facility has not had any other abuse allegations that have been reported by Adult Protective Services or any other outside agency that was not reported appropriately. 3.) Administrator and Director of Nursing to be in serviced by Regional Director of Clinical Services on the facility's policy for abuse investigation and reporting. Abuse allegations reported to the Facility by Adult Protective Services or any other outside agency will be reported to the state agency at the time the facility is made aware of the allegation. 4.) Facility will discuss abuse allegations and facility reported incidents five times a week at risk meeting for 12 weeks. Facility will discuss findings at monthly QAPI for meetings for three months. 5.) Date of Completion: 2/3/2017	

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F 225	Continued From page 3	F 225		

being over-medicated in the facility. As of 1/17/17 the state agency had received no facility reported incident or investigation of the allegation.

On 1/18/17 at 9:00 a.m. the administrator and director of nursing (DON) were interviewed regarding reporting and investigation of the allegation from APS regarding Resident #13. The administrator stated a representative from APS came to the facility on 1/5/17 and advised her of the allegation. The administrator stated the APS worker investigated the allegation and reported to her on 1/5/17 there was no evidence of abuse or neglect. The administrator stated she did not report the allegation to the state agency. The administrator stated she thought since an outside agency was aware of the allegation she did not need to report it to the state. The DON stated they reviewed the resident's clinical record related to the allegations but did not formally write an investigation.

The facility's abuse prevention policy (revised November 2016) stated, "It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, exploitation of residents, misappropriation of resident property and injuries of unknown source...The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy...The investigation must be completed within five (5) working days from the alleged occurrence...Evidence of the investigation should be documented..."

These findings were reviewed with the administrator and director of nursing during a

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F 225	Continued From page 4 meeting on 1/18/17 at 11:15 a.m. 2. A report from APS that Resident #9 was rough handled during her shower and personal care was not thoroughly investigated or reported to the state agency. Resident #9 was admitted to the facility on 11/20/16 with diagnoses including muscle weakness and depression. The most recent comprehensive MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 11/27/16. Resident #9 was assessed as being cognitively intact. Resident #9 was added to the survey sample due to an allegation of physical abuse, and was investigated by adult protective services (APS) and forwarded the investigation to the Office of Licensure and Certification (OLC). On 1/18/17 at 9:30 a.m. Resident #9 was interviewed concerning the allegation of being handled roughly during a shower and an aide refusing to take Resident #9 to the bathroom. Resident #9 denied any physical abuse by the staff at anytime and did not feel threatened by the staff or any visitors. Resident #9 did verbalized that a (CNA) certified nursing aide did brush her hair during a shower and felt that was a little rough, but verbalized that she (Resident #9) did not feel that it was intentional or a willful act of aggression. Resident #9 did not verbalized any concerns with staff taking her to the bathroom. Resident #9 could not remember who the shower aide was.	F 225		

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F 225	Continued From page 5 On 1/18/17 at 9:40 a.m. the administrator was interviewed concerning the above information. The administrator verbalized that on 1/5/17 APS entered the building to conduct an investigation concerning abuse for Resident #9. After the investigation was complete, the APS worker verbalized to the administrator that the allegations were unfounded and a report would follow. The administrator was asked (by the surveyor) if the facility reported the allegations to the state agency. The administrator verbalized that she did not report to the state agency and did not realize that she was supposed to. No other information was present prior to exit conference on 1/18/17.	F 225		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation	F 226		2/3/17

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F 226	Continued From page 6 requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to follow their abuse prevention policy for reporting and thoroughly investigating allegations of abuse/neglect for two of 14 residents in the survey sample. The facility failed to thoroughly investigate and report to the state agency a report from adult protective services (APS) alleging the facility over-medicated Resident #13 resulting in dehydration. A report from APS that Resident #9 was rough handled during her shower and personal care was not thoroughly investigated or reported to the state agency. The findings include: 1. The facility failed to follow their abuse prevention policy to thoroughly investigate and report to the state agency an APS allegation that the facility over-medicated Resident #13 resulting in dehydration. Resident #13 was admitted to the facility on	F 226	1.) Investigation completed on Resident # 13 and Resident #9 at the time APS made facility aware of the allegation of abuse. Facility wrote up formal investigation and submitted a late report to the state agency on 1/25/2017. 2.) Facility has not had any other abuse allegations that have been reported by Adult Protective Services or any other outside agency that was not reported appropriately. 3.) Administrator and Director of Nursing to be in serviced by Regional Director of Clinical Services on the facility's policy for abuse investigation and reporting. Abuse allegations reported to the Facility by Adult Protective Services or any other outside agency will be reported to the state agency at the time the facility is made aware of the allegation. 4.) Facility will discuss abuse allegations and facility reported incidents five times a week at risk meeting for 12 weeks.	

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F 226	Continued From page 7 12/13/16, re-admitted on 1/4/17 and died in the facility on 1/11/17. Diagnoses for Resident #13 included prostate cancer, chronic kidney disease, failure to thrive, atrial fibrillation and urinary tract infection. The minimum data set (MDS) dated 1/10/17 assessed Resident #13 with short and long-term memory problems and severely impaired cognitive skills. An adult protective services intake report dated 12/30/16 documented an anonymous allegation of neglect by the facility regarding care provided for Resident #13. The report documented an allegation the resident was hospitalized with severe dehydration resulting from being over-medicated in the facility. As of 1/17/17 the state agency had received no facility reported incident or investigation of the allegation. On 1/18/17 at 9:00 a.m. the administrator and director of nursing (DON) were interviewed regarding reporting and investigation of the allegation from APS regarding Resident #13. The administrator stated a representative from APS came to the facility on 1/5/17 and advised her of the allegation. The administrator stated the APS worker investigated the allegation and reported to her on 1/5/17 there was no evidence of abuse or neglect. The administrator stated she did not report the allegation to the state agency. The administrator stated she thought since an outside agency was aware of the allegation she did not need to report it to the state. The DON stated they reviewed the resident's clinical record related to the allegations but did not formally write an investigation. The facility's abuse prevention policy (revised November 2016) stated, "It is the facility's policy	F 226	Facility will discuss findings at monthly QAPI for meetings for three months. 5.) Date of Completion: 2/3/2017	

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F 226	Continued From page 8	F 226		

to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, exploitation of residents, misappropriation of resident property and injuries of unknown source...The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy...The investigation must be completed within five (5) working days from the alleged occurrence...Evidence of the investigation should be documented..."

These findings were reviewed with the administrator and director of nursing during a meeting on 1/18/17 at 11:15 a.m.

2. A report from APS that Resident #9 was rough handled during her shower and personal care was not thoroughly investigated or reported to the state agency.

Resident #9 was admitted to the facility on 11/20/16 with diagnoses including muscle weakness and depression.

The most recent comprehensive MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 11/27/16. Resident #9 was assessed as being cognitively intact.

Resident #9 was added to the survey sample due to an allegation of physical abuse, and was investigated by adult protective services (APS) and forwarded the investigation to the Office of

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F 226	Continued From page 9 Licensure and Certification (OLC). On 1/18/17 at 9:40 a.m. the administrator was interviewed concerning the above information. The administrator verbalized that on 1/5/17 APS entered the building to conduct an investigation concerning abuse for Resident #9. After the investigation was complete, the APS worker verbalized to the administrator that the allegations were unfounded and a report would follow. The administrator was asked (by the surveyor) if the facility reported the allegations to the state agency. The administrator verbalized that she did not report to the state agency and did not realize that she was supposed to. A Resident abuse policy was obtained from the facility and read in part: "Virginia Resident Abuse Policy [...] Date Revised: Oct. 2016, Nov. 2016" "Timing. All allegations of abuse[...] must be reported immediately* to the Administrator, Director of Nursing (DON) and to the applicable State Agency." ... "Final report will be submitted to applicable State agency, after the investigation is completed, but no later than five (5) working days from the alleged the alleged [SIC] occurrence." No other information was present prior to exit conference on 1/18/17.	F 226		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate	F 278		2/3/17

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SHENANDOAH NURSING HOME	**339 WESTMINISTER DRIVE** **FISHERSVILLE, VA 22939**

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F 278	Continued From page 10 each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate minimum data set (MDS) for one of 14 residents in the survey sample. A MDS for Resident #3 inaccurately assessed the resident with an unhealed pressure sore. The findings include:	F 278	1.) MDS assessment for Resident #3 was corrected at the time of the survey and a modification request was submitted. 2.) MDS Coordinator will audit all current resident's MDS assessments completed on residents with healed wounds to ensure that their most recent MDS assessment is accurate and no longer has a wound coded.	

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Continued From page 11

Resident #3 was admitted to the facility on 7/5/13 with diagnoses that included high blood pressure, arthritis and chronic arterial foot ulcers. The MDS dated 11/4/16 assessed Resident #3 with short and long-term memory problems and severely impaired cognitive skills.

Resident #3's clinical record documented a quarterly MDS with an assessment reference date of 11/4/16. Section M of this MDS listed the resident had an unhealed acquired unstageable pressure ulcer. The resident's clinical record including nursing notes and skin assessments for November 2016 made no mention of an unhealed pressure sore.

On 1/17/17 at 3:00 p.m. the licensed practical nurse (LPN #2) responsible for MDS assessments was interviewed about the Resident #3's having an unhealed pressure ulcer. After reviewing the MDS, LPN #3 stated the pressure ulcer assessment was inaccurate and should not have been entered on the MDS. LPN #3 stated the resident had only arterial ulcers and during November 2016 the resident did not have an unhealed pressure sore. On 1/18/17 at 9:50 a.m. LPN #3 stated the resident had a previous pressure ulcer that healed in September 2016. LPN #3 stated, "I just did not take it [pressure ulcer] off [the MDS]."

The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual on page M-4 defines a pressure ulcer as "localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction." This manual lists on pages M-4 and M-5 steps for assessment of pressure sores as,

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3.) In service education was provided by the Director of Nursing to the MDS Coordinator to no longer utilize the "pull recent value" function of the MDS. The MDS Coordinator will complete each section fully as if new to ensure that old data does not pull incorrectly.
4.) DON or designee will audit MDS assessments of residents with healed wounds to ensure that they are not coded inaccurately. Findings will be discussed at monthly QAPI meetings for three months.
5.) Date of Completion: 2/3/2017

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F 278	Continued From page 12 "Review the medical record, including skin care flow sheets or other skin tracking forms...Examine the resident and determine whether any skin ulcers are present...Identify any known or likely unstageable pressure ulcers...Code 0, no: if the resident did not have a pressure ulcer in the 7-day look-back period. Then skip Item M0300-M0800...Code1, yes: if the resident had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period..." (1) These findings were reviewed with the administrator and director of nursing during a meeting on 1/18/17 at 11:15 a.m. (1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.14, Centers for Medicare & Medicaid Services, Revised October 2016.	F 278		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident’s active record and use the results of the assessments to develop, review and revise the resident’s comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for	F 279		2/3/17

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each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

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F 279	Continued From page 14 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for one of 14 residents in the survey sample. Resident #3 had no care plan developed regarding vision and dental care. The findings include: Resident #3 was admitted to the facility on 7/5/13 with diagnoses that included high blood pressure, arthritis and chronic arterial foot ulcers. The MDS dated 11/4/16 assessed Resident #3 with short and long-term memory problems and severely impaired cognitive skills. Resident #3's clinical record documented the last comprehensive MDS was completed on 2/3/16 due to a significant change in condition. This MDS included the areas of dental and vision as triggered care concerns requiring a plan of care. The care area assessment summary documented facility staff decided to develop a care plan for the resident's dental and vision care concerns. Resident #3's care plan (revised 11/8/16) included no problems, goals and/or interventions regarding dental or vision problems. On 1/17/17 at 3:00 p.m. the licensed practical nurse (LPN #2) responsible for care plan development was interviewed about Resident	F 279	1.) Careplan for Resident # 3 was corrected at the time of the survey to indicate dental and vision needs. 2.) A 100% audit will be completed on current residents to ensure that they have a careplan to address any current dental and/or vision needs/problems. 3.) In service education provided to the MDS Coordinator and Social Worker to ensure that any triggered items on the care area assessment are addressed on the resident's current plan of care. 4.) MDS Coordinator will review care area assessments once the MDS is completed to ensure that any triggered areas are addressed appropriately on the resident's current plan of care for 12 weeks. Findings will be discussed at monthly QAPI meetings for three months. 5.) Date of Completion: 2/3/2017	

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F 279	Continued From page 15 #3's plan of care for dental and vision. LPN #2 reviewed the care plan and stated she did not see any entries on the care plan to address dental and vision concerns. LPN #2 stated the social worker was responsible for care plan development regarding vision. LPN #2 stated dental concerns were not typically part of the care plan unless there was a significant problem regarding dental care. LPN #2 stated the areas of dental and vision were marked on the care area assessment summary to require the development of a care plan. On 1/17/17 at 3:25 p.m. the facility's social worker was interviewed about a care plan regarding Resident #3's vision. The social worker stated the resident's vision may have triggered due to the potential for vision problems due to her age. The social worker stated she did not know why a vision care concerns were not added to the care plan. On 1/17/17 at 4:00 p.m. nurse manager (LPN #1) was interviewed about Resident #3's vision and dental care plan. LPN #1 stated Resident #3 wore dentures and that vision was an issue mostly likely due to the resident's history of a stroke and advanced age. LPN #1 did not know why these triggered care areas were not part of the care plan for Resident #3. These findings were reviewed with the administrator and director of nursing during a meeting on 1/18/17 at 11:15 a.m.	F 279		
F 328 SS=D	TREATMENT/CARE FOR SPECIAL NEEDS CFR(s): 483.25(b)(2)(f)(g)(5)(h)(i)(j) (b)(2) Foot care. To ensure that residents receive	F 328		2/3/17

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F 328	Continued From page 16 proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care,	F 328		

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including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, resident interview and clinical record review, the facility staff failed to follow physician orders for the care of a CPAP (continuous positive airway pressure) mask for one of 15 residents, Resident #11.

Resident #11's CPAP mask was not placed in a plastic bag while not in use on 01/17/2017 and 01/18/2017.

Findings were:

Resident #11 was originally admitted to the facility 09/01/2016. Her diagnoses included but were not limited to: Dementia, sleep apnea, obesity, hypertension and diabetes mellitus.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/18/2016. Resident #11 was assessed as being cognitively intact, with a summary score of "15".

F 328

1.) Resident #11's CPAP mask was placed in the bag per the physician order at the time of the survey.
2.) All residents with current CPAP orders are at risk. A 100% audit of was completed on residents with CPAP orders and observation rounds were made to ensure that their CPAP masks were bagged appropriately when not in use.
3.) All licensed nursing staff to be inserviced on following physician orders to bag CPAP masks when not in use by the resident.
4.) Random weekly audits will be conducted by the DON or designee to ensure that CPAP masks are bagged per physician orders when not in use. Will discuss weekly at Clinical Review meetings for 12 weeks. Will discuss findings at monthly QAPI meetings for three months.
5.) Date of Completion: 2/3/2017

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F 328	Continued From page 18 On 01/17/2017 at approximately 3:30 p.m., Resident #11 was interviewed regarding her life at the facility. During the interview a CPAP machine was observed on her bedside table. Attached to the machine was tubing and attached to the tubing was a CPAP mask. The mask was laying on a table beside the bed. A plastic bag was laying next to the mask. Resident #11 was asked if her CPAP mask was ever put in the plastic bag laying beside of it. She stated, "I thought the CNA [certified nursing assistant] was suppose to do it...I guess she forgot." On 01/18/2017 at approximately 8:00 a.m., the electronic record was reviewed. Observed on the physician order sheet was the following order: "CPAP remove mask in AM and place in bag to store when not in use, in the morning for sleep apnea." The care plan was reviewed. The focus area "...has diagnosis of Obstructive Sleep Apnea and has need for CPAP at HS [hour of sleep] Interventions included, but were not limited to: "Care for mask and tubing as per MD [medical doctor] order." On 01/18/2017 at approximately 9:30 a.m., Resident #11 was observed lying in bed. Her CPAP mask was laying on the table at her bedside. It was not in the plastic bag as ordered. CNA #1 who was caring for Resident #11 was interviewed regarding the CPAP mask. She stated that she didn't know anything about it. CNA #1 went to the Kardex care plan for the CNAs and looked. There were no interventions/tasks for the CNAs regarding the CPAP.	F 328		

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RN [Registered nurse} #1 was interviewed. She stated that she was taking care of name of Resident #11). She stated that she had not been in the room yet. She stated that Resident #11 removed her CPAP mask herself in the mornings when she woke up. RN #1 checked the electronic TAR (Treatment administration record). She stated, "I don't see anything about the CPAP mask on here."

This surveyor returned to the conference room and pulled up the TAR. The entry "CPAP remove mask in the AM and place in bag to store when not in use. In the morning for sleep apnea." The treatment was scheduled to be done at 6:30 a.m. and was signed off as having been completed on both 1/17/2017 and 01/18/2018 by two different nurses.

This surveyor returned to RN #1 and discussed the above information. She stated, "That's why it isn't showing up for me. I only see the treatments and medications for day shift."

The DON (Director of Nursing) was asked for any policy the facility had regarding the care of CPAP equipment/machines. She stated that the care of the CPAP mask and machine were physician orders and there was no specific policy. She also stated that CNAs did not care for the CPAP nor were they responsible for putting it in the bag as ordered by the physician.

The DON and the administrator were notified of the above information during an end of the day meeting on 01/18/2017.

No further information was obtained prior to the

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F 328	Continued From page 20 exit conference on 01/18/2017.	F 328		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		2/3/17

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F 431	Continued From page 21 (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, facility staff failed to label and store drugs and biologicals properly in the medication room. Facility staff failed to discard an expired box of Hemoccult slides, failed to date an open bottle of Hemoccult developer and an opened bottle of Flu vaccine. Findings included: On 01/18/17 at 9:30 a.m. the ADON (assistant director of nursing) and this surveyor inspected the medication room on the nursing unit. During this inspection a box of Hemoccult slides with an expiration date of 05/16 and two bottles of Hemoccult developer with an expiration date of 11/16 were noted. One bottle of Hemoccult developer was also found opened and not dated.	F 431	1.) Hemoccult slides and developer were discarded at the time of the survey. Flulaval (Flu Vaccine) was discarded at the time of the survey. 2.) A 100% audit of drugs and biologicals was completed in the medication room. 3.) All licensed nurses will be in serviced on proper storage and labeling of drugs and biologicals to ensure that all items are labeled correctly and in current date. 4.) DON or designee will conduct random weekly audits for 12 weeks on the medication room and medication refrigerator to ensure items are in date and labeled appropriately. Findings will be discussed at monthly QAPI meetings for three months. 5.) Date of Completion: 2/3/2017	

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F 431	Continued From page 22 The Hemoccult slides and developer were in a cabinet with house stock medications. The ADON stated, "We don't do very often. I will discard all of it." In the medication refrigerator a multi-dose vial of Flulaval (Flu Vaccine) 5ml (milliliters) was noted as opened and not dated. The ADON inspected the vial of Flu Vaccine and the box and stated, "It wasn't dated when it was opened. It should have been dated when opened." Facility policy "5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, Effective Date: 12/01/07, Revision Date: ...10/31/16..."stated, "...Procedure ...4. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3)...are stored separate from other medications until destroyed or returned to the pharmacy or supplier. 5. Once any medication or biological package is opened...Facility staff should record the date opened on the medication container..." The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 01/18/17 at 11:10 a.m. No further information was received prior to the exit conference.	F 431		