golden living®

Enhancing lives through innovative healthcare™

November 23, 2016

Mr. Paul Wade, LTC Supervisor
Division of Long Term Care
Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive
Suite 401
Richmond, VA 23233

RE: Golden Living Shenandoah Valley
Provider Number: 495168

Dear Mr. Wade,

Attached is our Plan of Correction in response to the standard annual survey ending November 3, 2016.

If additional information is needed or if you should have any questions please let me know.

Sincerely,

Ann Marie Parks
Executive Director

www.goldenliving.com
3737 Catalpa Ave.
Buena Vista, VA 24416 • Phone: 540-261-7444 • Fax: 540-261-7739

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	495168		11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-SHENANDOAH VALLEY	3737 CATALPA AVE, PO BOX 711 BUENA VISTA, VA 24416

(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) COMPLETE DATE
F 000	Initial Comments	F 000	Golden Living Center Shenandoah Valley ("Facility") is filing this Plan of Correction for purposes of regulatory compliance. The Facility is submitting this Plan of Correction to comply with applicable law. The submission of the Plan of Correction does not represent an admission or statement of agreement with respect to the alleged deficiencies.	
	An unannounced biennial State Licensure Inspection was conducted 11/01/2016 through 11/03/2016. Two complaints were investigated during the survey. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 93 bed facility was 74 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents #1 through #13) and two (2) closed record reviews (Residents #14 and #15).			
F 001	Non Compliance	F 001		
	The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities.			
	Cross Reference 12VAC5-371-250(A) to F-278.		Cross reference to POC F-278	
	Cross Reference 12VAC5-371-250(A) to F-279.		Cross reference to POC F-279	
	Cross Reference 12VAC5-371-250 to F-280.		Cross reference to POC F-280	
	Cross Reference 12VAC5-371-220(C)(3) to F-315.		Cross reference to POC F-315	
	Cross Reference 12VAC5-371-300(A) to F-425.		Cross reference to POC F-425	
	Cross Reference 12VAC5-371-310(A) to F-502.		Cross reference to POC F-502	
	32.1-126.01(A) - Code of Virginia			
	Based on staff interview, facility document review			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	11/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	11/03/2016
NAME OF PROVIDER OR SUPPLIER: GOLDEN LIVINGCENTER-SHENANDOAH VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE: 3737 CATALPA AVE, PO BOX 711 BUENA VISTA, VA 24416	

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F 001	Continued From Page 1	F 001	32. 1-126.01 (A) – Code of Virginia	

and employee file review, facility staff failed to obtain a Virginia State Police criminal background check within 30 days of hire for three of 25 employees.

Employee #15 was hired 02/12/2016 and his criminal background check was obtained 12/31/2015, 42 days prior to his official hire date. Employee #18 was hired 06/20/2016 and her criminal background check was not obtained until 09/28/2016. Employee #23 was hired 08/29/2016 and no criminal background check had been obtained as of 11/03/2016.

On 11/03/2016 at approximately 8:50 a.m., RN #3 (registered nurse), also serving as the facility HR (human resource) employee was interviewed regarding the missing State Police criminal background checks. RN #3 showed this surveyor a paper that had been obtained from the corporate office listing the three individuals and the date a criminal background check had been requested and received. No actual criminal background report was visualized. RN #3 stated, "I will have to email the corporate office and see if they have the actual state police reports. This is all they sent me." At approximately 9:30 a.m., RN #3 entered the conference room and informed this surveyor, "They (corporate) do not have actual Virginia State Police background checks for those three. So we are out of compliance with those three."

The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 11/03/2016 at 10:00 a.m. No further information was received by the survey team prior to the exit conference on 11/03/2016.

1. Employee #15 is no longer employed at the facility. Employee #18 and #23 remain employed at the facility. Criminal background check has been obtained for employee #23.
2. All employees have the potential to be affected by this deficient practice. DCE/Designee will maintain a Virginia State Background log to ensure all new hire employees have a background check within 30 days of hire.
3. Executive Director to educate Director of Clinical Education on process of obtaining criminal background checks of all new hires within a timely manner. All Virginia State Criminal Background checks will be obtained in-house by DCE/Designee.
4. DCE/Designee will maintain a Virginia State Background log to ensure all new hire employees have a background check within 30 days of hire. Results will be taken to QAPI monthly for review and recommendations for three months, the QAPI committee will be responsible for on-going compliance.
5. Corrective action will be completed by December 12, 2016.

Nursing Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 001 Continued From Page 2

12 VAC 5-371-220 (F). "Each resident shall receive tub or shower baths as often as needed, but not less than twice weekly. Residents whose medical conditions prohibit tub or shower baths shall have a sponge bath daily."

Based on complaint investigation, clinical record review, and staff interview, the facility staff failed for three of 15 residents in the survey sample (Residents # 1, 9 and 12) to provide at least two tub or shower baths per week.

The findings include:

1. Resident # 1 in the survey sample, a 77 year-old female, was admitted to the facility on 1/7/09, and readmitted on 1/15/15 with diagnoses that included mental retardation, gastroesophageal reflux disease, osteoporosis, Vitamin B-12 deficiency, hyperparathyroidism, hyperlipidemia, epilepsy, hypertension, and depressive disorder. According to the most recent Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/24/16, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 10 out of 15. Under Section G (Functional Status), the resident was assessed as being totally dependent with one person physical assist for bathing.

According to the Bathing Type Detail Reports for the month of September 2016, Resident # 1 received one bath during the week of 9/4/16 through 9/10/16, and one bath during the week of 9/11/16 through 9/17/16. There was no documentation to indicate why two baths were not provided, or that the resident refused bathing.

The findings were addressed during an end of day

F 001

12 VAC 5-371-220 (F)

1. Resident #1, #9, and #12 remain in the facility. It has been validated that these residents have received two (2) showers a week for the month of November. Shower log will be reviewed to assure all showers given and documented weekly.
2. All residents have the potential to be affected by this deficient practice. DNS/Designee will review all shower logs to assure showers have been given and documented weekly.
3. Shower logs will be reviewed to assure showers have been given and documented. Validation that all residents have received a minimum of two (2) baths weekly will be done 5 days a week.
4. DNS/Designee will review all shower logs to assure showers have been given and documented. Validation that all residents have received a minimum of two (2) baths weekly will be done 5 days a week. Results will be taken to QAPI monthly for review and recommendations for 3 months, with the QAPI committee responsible for ongoing compliance.
5. Corrective action will be completed by December 12, 2016.

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meeting at 4:00 p.m. on 11/2/16 that included the Administrator, Director of Nursing, Assistant Director of Nursing, and the survey team.

2. Resident # 9 in the survey sample, a 91 year-old female, was admitted to the facility on 9/25/15 with diagnoses that included chronic obstructive pulmonary disease, anemia, asthma, pain, dementia with behavioral disturbances, and edema. According to a Quarterly MDS with an ARD of 8/24/16, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with Summary Score 4 out of 15. Under Section G (Functional Status), the resident was assessed as being totally dependent with one person physical assist for bathing.

According to the Bathing Type Detail Reports for the month of September 2016, Resident # 9 received on shower during the week of 9/25/16 through 10/1/16. There was no documentation to indicate why two baths were not provided, or that the resident refused bathing.

The findings were addressed during an end of day meeting at 4:00 p.m. on 11/2/16 that included the Administrator, Director of Nursing, Assistant Director of Nursing, and the survey team.

3. Resident # 12 in the survey sample, a 92 year-old female, was admitted on 5/7/09 with diagnoses that included dementia with behavioral disturbances, Parkinsonism, macular degeneration, depressive disorder, age-related osteoporosis, anxiety disorder, and hypertension. According to a Quarterly MDS with an ARD of 9/14/16, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with Summary Score 3 out of 15. Under Section G (Functional Status), the resident was assessed as being totally dependent

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with two persons physical assist for bathing.

According to the Bathing Type Detail Reports for the month of September 2016, Resident # 13 received on bath during the week of 9/4/16 through 9/10/16, and no baths during the week of 9/25/16 through 10/1/16. For the month of October 2016, Resident # 12 received one bath during the weeks of 10/2/16 through 10/8/16, and the week of 10/9/16 through 10/15/16. There was no documentation to indicate why two baths were not provided, or that the resident refused bathing.

The findings were addressed during an end of day meeting at 4:00 p.m. on 11/2/16 that included the Administrator, Director of Nursing, Assistant Director of Nursing, and the survey team.

COMPLAINT DEFICIENCY

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

PRINTED: 11/15/2016
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER: GOLDEN LIVINGCENTER-SHENANDOAH VALLEY

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F 000	INITIAL COMMENTS	F 000	Golden Living Center Shenandoah Valley ("Facility") is filing this Plan of Correction for purposes of regulatory compliance. The Facility is submitting this Plan of Correction to comply with applicable law. The submission of the Plan of Correction does not represent an admission or statement of agreement with respect to the alleged deficiencies.	
	An unannounced Medicare/Medicaid standard survey was conducted 11/01/2016 through 11/03/2016. Two complaints were investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 93 certified bed facility was 74 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents #1 through #13) and two (2) closed record reviews (Residents #14 and #15).			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278	1. Resident #4 remains in the facility. A corrected Quarterly Minimum Data Assessment set has been completed to reflect resident #4 received total assistance of 2 for bathing during assessment period. 2. All residents have the potential to be affected by this deficient practice. DNS/Designee will do weekly audits of Minimum Data Sets under Section G to validate this section has been completed to reflect all residents have received a bath/shower. 3. Education will be provided by the Director of Clinical Education to the Shower Team to complete shower log and log all showers or bathing type in Kiosk. Education will be provided to the MDS Coordinator/Assistant to validate all residents have received a bath/shower during Minimum Data Set reference period. Validation that all residents	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 11/23/16

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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resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

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, facility staff failed to ensure a complete and accurate MDS (minimum data set) assessment for one of 15 residents in the survey sample, Resident #4.

Facility staff coded Section G - Functional Status, G0120. Bathing incorrectly for Resident #4.

Findings included:

Resident #4 was admitted to the facility on 06/17/2015 with diagnoses including, but not limited to: Dementia with Behaviors, Hypertension, Atrial Fibrillation, Anxiety and Iron Deficiency Anemia.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/07/2016. Resident #4 was assessed as severely impaired in cognitive status with a total cognitive score of one out of 15.

Resident #4's clinical record was reviewed 11/01/2016 at 1:50 p.m. During this review the most recent MDS dated 09/07/2016 included the following information. Section G0120 was coded as 8/8 for Resident #4, meaning the activity of bathing had not occurred for this resident during

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have received a minimum of two (2) baths weekly will be done 5 days a week by DNS/Designee.

4. DNS/Designee will do weekly audits of MDS Minimum Data Sets under Section G to validate this section has been completed to reflect all residents have received a bath/shower. Results will be taken to QAPI monthly for review and recommendations for 3 months, with the QAPI committee responsible for ongoing compliance.
5. Corrective action will be completed by December 12, 2016.

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the seven day look back period. "Section G - Functional Status: G0110. Activities of Daily Living (ADL) Assistance...1. ADL Self-Performance - Code for resident's performance over all shifts...Coding: ...8. Activity did not occur - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period. 2. ADL Support Provided - Code for most support provided over all shifts; code regardless of resident's self-performance classification. Coding: ...8. ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period...G0120. Bathing A. Bathing: Self-performance...8. Activity itself did not occur. B. Bathing: Support provided: 8. ADL activity itself did not occur." CMS's RAI Version 3.0 Manual, CH 3: MDS Items [G], October 2016, Page G-34 includes the following:
"DEFINITION
BATHING
How the resident takes a full body bath, shower or sponge bath, including transfers in and out of the tub or shower. It does not include the washing of back or hair.
Coding Instructions for G0120A, Self-Performance
Code for the maximum amount of assistance the resident received during the bathing episodes.
· Code 8, ADL activity itself did not occur during entire period: if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.
Coding Instructions for G0120B, Support Provided
· Bathing support codes are as defined ADL Support Provided item (G0110), Column 2.

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F 278	Continued From page 3 Section G - Functional Status: G0110. Activities of Daily Living (ADL) Assistance 2. ADL Support Provided - Code for most support provided over all shifts; code regardless of resident's self-performance classification. Coding: ...8. ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period. (1) RN #1 (registered nurse) was interviewed 11/03/2016 at 8:20 a.m. regarding the coding on Resident #4's MDS dated 09/07/2016. RN #1 stated, "Someone else, who is no longer here completed her MDS. I don't know why she completed it the way she did. Normally I would talk to the shower team and investigate a little more. I did go back and review her bathing records for that week and she did receive all her baths. I have submitted a corrected MDS." The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team 11/03/2016 at approximately 9:30 a.m. No further information was received by the survey team prior to the exit conference on 11/03/2016. (1) CMS's RAI Version 3.0 Manual, CH 3: MDS Items [G], October 2016, Page G-34	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279	1. Resident #9 remains in the facility. A comprehensive care plan addressing cognitive impairment for Resident #9 with interventions has been implemented and placed on care plan for this resident.	

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objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility staff failed for one of 15 residents in the survey sample (Resident # 9) to develop a plan of care to address the resident's use of Lorazepam. Resident # 9 had a physician's order for Lorazepam as needed to address anxiety and/or aggression.

The findings were:

Resident # 9 in the survey sample, a 91 year-old female, was admitted to the facility on 9/25/15 with diagnoses that included chronic obstructive pulmonary disease, anemia, asthma, pain, dementia with behavioral disturbances, and edema. According to the most recent Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/1/16, and the most recent Quarterly MDS with an ARD of 8/24/16, the resident was assessed under Section C (Cognitive Patterns) as being severely

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2. All residents receiving anti-anxiety medications will be reviewed to ensure plan of care reflects the use of this medication and appropriate interventions are in place.
3. Education will be provided by the Director of Clinical Education or designee, to licensed nursing staff and RNAC to implement a comprehensive care plan.
4. Random weekly audits will be done on care plans to validate residents that trigger and use of psychotropic medication will have comprehensive care plan completed. Results will be taken to QAPI monthly for review and recommendations for three (3) months, with the QAPI Committee responsible for on-going compliance
5. Corrective action will be completed by December 12, 2016.

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cognitively impaired, with Summary Scores of 3 out of 15 and 4 out of 15 respectively.

Resident # 9 had the following physician's order, dated 4/23/16:

Lorazepam Tablet 1 mg (milligram). Give 1 mg by mouth as needed for anxiety and/or agitation QD (every day) PRN (as needed).

(NOTE: Lorazepam (Ativan) is a short acting benzodiazepine used to treat anxiety and irritability with psychiatric or organic disorders. Given orally, it has an onset of one hour with a peak of two hours. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 722.)

Review of the Electronic Medication Administration Record (EMAR) for the months of September, October, and November 2016 revealed the resident was administered as needed Lorazepam seven times between 9/7/16 and 11/2/16.

Resident # 9's care plan, developed on 10/19/15, and revised on 9/14/16, included the following problem, "At risk for mood and behaviors secondary to yelling, combative, cursing, resisting care, refusing meds (medications) and supplements, meals, O2 (oxygen), vital signs." The goal for the problem was, "Will be easily redirected over the next 90 days."

The interventions to the stated problem were, "Always approach resident in calm manor (sic). Explain all procedures and reason before performing. Listen to resident and provide problem solving if possible. Attempt to refocus behavior to be positive. Stop care when resident

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NAME OF PROVIDER OR SUPPLIER
GOLDEN LIVINGCENTER-SHENANDOAH VALLEY

STREET ADDRESS, CITY, STATE, ZIP CODE
3737 CATALPA AVE, PO BOX 711
BUENA VISTA, VA 24416

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F 279	Continued From page 6 is upset and try again later. Encourage Activities of resident choice. Notify MD if mood/behavior interferes with functioning. Assess for pan. Offer food and fluids. Medications as ordered." The care plan was silent as to the use of Lorazepam on an as needed basis to address Resident # 9's anxiety and/or aggression. The findings were addressed during an end of day meeting at 4:00 p.m. on 11/2/16 that included the Administrator, Director of Nursing, Assistant Director of Nursing, and the survey team.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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.	F 280	1. Resident #13 remains in the facility. Comprehensive care plan has been updated to reflect decline in resident's physical and cognitive condition. 2. All residents in the facility have the potential for an inaccurate/incomplete care plan, will monitor all residents care plans that have had a significant change to their overall condition to ensure the care plan reflects resident's current condition. 3. Education will be provided by the Director of Clinical Education/designee to the Interdisciplinary Care Plan Team to ensure the care plan has been updated to reflect all changes in resident's overall condition. 4. DNS/RNAC/Designee will monitor all residents care plans that have had a significant change to their overall condition to ensure the care plan reflects resident's current condition.	

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This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review, the facility staff failed to revise the comprehensive care plan for one of 15 residents in the survey sample. Resident #13's care plan was not updated with interventions addressing a significant decline in cognition, bowel/bladder function and an increase in help with dressing, toileting and hygiene.

The findings include:

Resident #13 was admitted to the facility on 7/11/16 with diagnoses that included history of lung cancer, chronic obstructive pulmonary disease (COPD), anxiety, heart failure and chronic pain. The minimum data set (MDS) dated 9/14/16 assessed Resident #13 with severely impaired cognitive skills.

The admission MDS dated 7/18/16 assessed Resident #13 with moderately impaired cognitive skills, independent with bed mobility, toileting, hygiene and ambulation, requiring supervision only with dressing, and as always continent of bowel and bladder.

A physician's progress note dated 9/6/16 documented, "...seen 9/6/16 due to resident having decline in condition. Nursing reported resident to be more confused, unsteady gait when up to BR [bathroom], incontinent episode bowel and bladder which is unusual..."

Resident #13's MDS dated 9/14/16 completed due to a significant change in condition documented an assessed decline in function in multiple areas. This MDS listed the resident with

F 280

Significant change care plans will be monitored weekly over the next three (3) months to ensure they are current and accurate. Results will be taken to QAPI monthly for review and recommendations for three (3) months, with the QAPI Committee responsible for on-going compliance

5. Corrective action will be completed by December 12, 2016.

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F 280	Continued From page 8 severely impaired cognitive skills, a requirement for extensive assistance of one person for bed mobility, transfers, dressing, toileting/hygiene and as frequently incontinent of bowel/bladder. A nursing note dated 9/28/16 documented, "Resident is currently receiving hospice services. Resident has been requiring more assistance for ADLs [activities of daily living] and transfers recently..." The resident's plan of care (revised 9/28/16) included no problems, goals and/or interventions addressing the resident's significant decline in activities of daily living and cognition. The plan listed the resident had self-care deficits and impaired mobility but had not been revised to address these deficits since 7/11/16. The care plan problems, goals and interventions regarding impaired cognition were dated 7/21/16 and were not revised to address the resident's assessed decline in cognitive status on 9/14/16. On 11/2/16 at 2:25 p.m. the registered nurse (RN#1) responsible for care plans was interviewed about Resident #13's decline. RN #1 stated the resident had a care plan review meeting on 9/21/16. RN #1 stated the resident had experienced an overall decline and was now on hospice care. RN #1 stated staff members were providing increased assistance as needed for Resident #13. RN #1 stated hospice was added to the resident's care plan on 9/21/16 but the increased assistance provided was not updated to the plan. On 11/3/16/ at 8:20 a.m. RN #1 was interviewed again about any updates to Resident #13's care plan regarding his decline in function. RN #1	F 280		

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F 280	Continued From page 9 stated the interventions implemented to provide increased assistance for Resident #13 had not been added to the care plan. These findings were reviewed with the administrator and director of nursing during a meeting on 11/2/16 at 3:45 p.m.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to implement interventions to restore bladder function for one of 15 residents in the survey sample. Resident #13, always continent of urine upon admission to the facility, had no interventions implemented to regain or maintain continence when assessed with a loss of bladder function. The findings include: Resident #13 was admitted to the facility on 7/11/16 with diagnoses that included history of lung cancer, chronic obstructive pulmonary	F 315	1. Resident #13 remains in the facility. We will track the resident's bladder pattern for 72 hours. Upon completion the appropriate bladder program will be implemented. 2. All residents have the potential to be affected by this deficient practice. The Bladder Function Assessment will be monitored weekly. 3. The Director of Clinical Education/designee will educate licensed nursing staff regarding the urinary incontinence guidelines to implement 72 hour tracking tool if indicated by the Bladder Function Assessment. 4. The Interdisciplinary Care Plan Team will monitor compliance of the Bladder Function Assessment and the required tracking form weekly during care plan meetings. The Bladder Function Assessment will be monitored weekly over the next three (3) months to ensure they are current and accurate. Results will be taken to QAPI monthly for review and recommendations for three (3) months, with the QAPI Committee responsible for on-going compliance. 5. Corrective action will be completed by December 12, 2016.	

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F 315	Continued From page 10 disease (COPD), anxiety, heart failure and chronic pain. The minimum data set (MDS) dated 9/14/16 assessed Resident #13 with severely impaired cognitive skills and as frequently incontinent of urine (7 or more episodes of urinary incontinence, but at least one episode of continent voiding during look back period). Resident #13's clinical record documented the resident as always continent of urine upon admission to the facility on 7/11/16. The admission MDS dated 7/18/16 and 30 day MDS dated 8/8/16 listed the resident as "always continent" of urine. The MDS dated 9/14/16 completed due to a significant change in condition assessed Resident #13 as frequently incontinent of bladder. Resident #13's clinical record documented a bladder function evaluation form dated 7/11/16. This evaluation assessed Resident #13 to have at least one incontinent episode per day and documented the resident as a good candidate for the restorative nursing program. This evaluation documented the resident required a tracking of his bladder patterns for three days to determine the appropriate bladder program. Program options to regain/improve bladder function were listed as prompted voiding, scheduled toileting, habit training, bladder retraining and care/comfort. The clinical record documented no 3 day tracking of Resident #13's bladder patterns. A physician's progress note dated 9/6/16 documented, "...seen 9/6/16 due to resident having decline in condition. Nursing reported resident to be more confused, unsteady gait when up to BR [bathroom], incontinent episode	F 315		

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bowel and bladder which is unusual..."

An additional bladder function evaluation form was completed on 9/10/16. This assessment listed Resident #13 had experienced a decline in bladder function and was always incontinent of urine. The form documented the resident as a "fair" candidate for the restorative nursing program and indicated the need for tracking bladder patterns for three days. The clinical record documented no 3 day tracking of Resident #13's bladder patterns following this assessment.

The resident's plan of care (revised 9/28/16) listed the resident as frequently incontinent of bladder but included no goals and/or interventions to address the decline in bladder function.

On 11/2/16 at 3:00 p.m. the registered nurse (RN #1) responsible for MDS assessments and care plan development was interviewed about any interventions regarding Resident #13's decline in bladder function. RN #1 stated the resident had experienced an overall decline since his admission to the facility and was now on hospice care. When asked if the bladder pattern tracking forms were completed as listed on the bladder evaluations, RN #1 stated, "No." RN #1 stated she was not sure there was a bladder tracking tool. RN #1 stated facility staff members were providing increased assistance due to the resident's decline but there were no toileting programs implemented. RN #1 stated she felt the decline in bladder function was due to the resident's overall decline. RN #1 was not aware of any interventions implemented to address Resident #13's incontinence.

On 11/2/16 at 3:20 p.m. certified nurses' aide

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(CNA #2) that routinely cared for Resident #13 was interviewed about the resident's decline in bladder function. CNA #2 stated Resident #13 was most always continent of urine when first admitted but was now mostly incontinent. CNA #2 stated Resident #13 was not on a scheduled toileting program. CNA #2 stated she just checked his brief throughout the shift and changed him when he was found wet. CNA #2 stated the resident at times used the restroom without asking for assistance.

On 11/2/16 at 3:25 p.m. CNA #3 caring for Resident #13 was interviewed about his bladder function. CNA #3 stated Resident #13 "goes [to restroom] on his own some" but was no longer continent of urine. CNA #3 stated the resident was not on any type of scheduled toileting program.

On 11/2/16 at 3:30 p.m. the licensed practical nurse (LPN #1) caring for Resident #13 was interviewed about any interventions regarding his loss of urinary continence. LPN #1 stated the resident had declined and was now on hospice. Concerning his bladder function, LPN #1 stated, "He [Resident #13] still goes on his own some and sometimes goes in his brief." LPN #1 stated Resident #13 was "not continent anymore." LPN #1 stated she was not aware of any interventions implemented regarding his incontinence.

On 11/2/16 at 3:45 p.m. the registered nurse unit manager (RN #4) was interviewed about Resident #13. RN #4 presented a copy of a Bowel and Bladder Record Data Collection Tool. RN #4 stated this form was supposed to be used for tracking bladder patterns. RN #4 stated this form should have been completed and reviewed

F 315

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F 315	Continued From page 13 following the bladder evaluations completed on 7/11/16 and 9/10/16 to determine what type of retraining or program was appropriate to address the decline. RN #4 stated they were providing increased assistance for the resident but no specific interventions had been implemented regarding Resident #13's decline in bladder continence. These findings were reviewed with the administrator and director of nursing during a meeting on 11/2/16 at 3:45 p.m.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, facility staff failed to provide supervision and interventions for the prevention of accidents and injuries for four of 15 residents in the survey sample, Residents #15, #11, #5 and #6. 1.a. Resident #15 did not have interventions in place to prevent a fall with injury and resulting harm on 06/22/2016. 1.b. Resident #15 did not have interventions in	F 323	1. Resident #15 no longer resides in the facility. Resident had interventions implemented for all falls. Resident #11 no longer resides in the facility. Resident had interventions implemented for all falls Resident #5 remains in the facility. Resident #5 continues to have order for lidded cup for all meals. This adaptive equipment noted on tray ticket. Care plan updated on day of survey. Resident #6 remains in the facility. Anti-tipper replaced on wheelchair on day of survey. 2. All residents have the potential to be affected by this deficient practice. DNS/Designee will audit all residents who had a fi\all in the last 30 days to review the fall prevention and fall risk plan of care, the plan of care will be revised at indicated. DNS/Designee will audit all who have anit-tippers to validate proper functioning of anti-tippers. DNS/Designee	

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place to prevent a fall with injury and resulting harm on 07/20/2016.

2. Resident #11 did not have interventions in place to prevent a fall with injury and resulting harm on 10/01/2016.

3. Resident #5 suffered a burn on 09/19/2016 when she spilled hot coffee on her lap during lunch.

4. Resident #6 did not have wheelchair anti-tippers in use as required in her plan of care for fall prevention.

Findings included:

Resident #15 was originally admitted to the facility on 05/01/2015 and readmitted on 05/09/2016 with diagnoses including, but not limited to: Dementia with Behaviors, Left Femur Fracture, Macular Degeneration, Insomnia and TIA (transient ischemic attacks - mini strokes).

The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 07/05/2016. Resident #15 was assessed as severely impaired in her cognitive status with a total cognitive score of three out of 15.

1.a. Resident #15 did not have interventions in place to prevent a fall with injury and resulting harm on 06/22/2016.

Resident #15's closed clinical record was reviewed 11/02/2016 at approximately 11:25 a.m.

Review of Nursing Progress Notes revealed

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will review all residents with orders with lidded cups to ensure plan of care is in place as ordered.

3. Interdisciplinary team will evaluate fall risk upon admissions, post fall, with changes in condition, and quarterly and implement interventions as indicated per resident assessment and will review and revise care plan accordingly. All staff will be educated reading fall management guidelines.
4. DNS/Designee and the Interdisciplinary team will review residents with falls to evaluate fall plan of care and will revise fall plans of care as indicated. DNS/Designee will conduct will conduct random audits weekly x8 weeks and then monthly of meals to ensure residents are served with lidded cups per physician orders. DNS/Designee will conduct weekly audits x8 weeks and then monthly to validate residents with anti-tippers have properly functioning anti-tippers in place. All results of audits will be reported to the Quality Assurance Committee monthly.
5. Corrective action will be completed by December 12, 2016.

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F 323	Continued From page 15 Resident #15 fell a total of five times from January 2016 through August 2016. Three of those falls resulted in injury, two of the three resulted in harm. Resident #15 fell on 01/25/2016. Gripper socks and a bed alarm were added to the care plan at that time. The second fall occurred 05/05/2016 at the nurse ' s station and was witnessed. This fall resulted in a fractured hip. Resident #15 was admitted to the hospital from 05/05/2016 through 05/09/2016 and had her hip fracture repaired. Resident #15 was readmitted to the facility on 05/09/2016. The only fall precaution initiated upon Resident #15 ' s readmission was to place anti-tippers on her wheelchair. In addition, Resident #15 did receive physical therapy after her readmission. However, as her mobility progressed, no other fall precautions were ever initiated. Resident #15 fell on 06/22/2016 in her bathroom that resulted in a fractured nose. Educate staff to toilet resident before and after meals and before bedtime was added to the care plan. On 07/20/2016 Resident #15 fell again and required five staples to the back of her head. Will place resident in a low bed was added to the care plan. Resident #15 again fell on 08/03/2016. Right side of bed to wall and landing strips placed on the floor was added at that time. Alarms were never restarted after Resident #15 '	F 323		

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F 323	Continued From page 16 s readmission to the facility on 05/09/2016. Interventions were added reactively after each fall, not proactively. The actual Nursing Progress Notes included the following documentation: "01/25/2016 04:21 (4:21 a.m.)..Change of Condition: Situation: Resident yelling 'help' from room. Resident was found by this nurse sitting on floor in residents room facing doorway. Residents walker was at bedside...Assessment: ...Gripper socks applied and reminded resident to use walker for ambulation...Raised bruise/contusion was found on left inner buttocks...Multiple times of resident getting up unassisted and not using call bell. Bed alarm was put in place to alert staff of ambulation..." "5/5/2016 20:11 (8:11 p.m.)...Change of Condition: Situation: Resident fell on the floor by the nurses desk...Assessment: Resident had witnessed fall by the nurses desk. Resident had got up out of w/c (wheelchair) without assistance and fell to left side. Resident hit head on floor although no injury to head noted. Complains of increased pain in left hip/pelvic area..." Resident incurred a left femur fracture. Resident #15 was readmitted to the facility on 05/09/2016 after surgical repair of her left hip fracture. According to documentation in the clinical record no specific fall interventions were implemented upon readmission to the facility except "...Will place anti-rollbacks to w/c to prevent chair from rolling if resident attempts to stand unassisted....," per Resident #15's care plan.	F 323		

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"6/22/2016 15:50 (3:50 p.m.)...Change of Condition: Situation: Resident fell...Assessment: Nurse heard yelling out. Nurse walked into room and found resident in bathroom on knees with face near toilet. Large amount of bright red blood present. Resident has 2 areas to nose which were bleeding-steri-strips applied. Noted to have abrasive area to left knee, right knee is red..." Per the care plan, "...6/23/16-Will educate staff to offer toileting upon rising, AC (before meals), PC (after meals), and HS (bed time..." As previously mention, no other fall interventions added at that time according to documentation in the clinical record.

"6/27/2016 10:34 General Note: ...MD (physician) in to visit, new order noted to schedule x-ray of face-nose to r/o (rule out) fx (fracture)..."

"6/28/2016 12:35 General Note: ...Xray noted that nose is broken..."

1.b. Resident #15 did not have interventions in place to prevent a fall with injury and resulting harm on 07/20/2016.

"7/20/2016 18:21 (6:21 p.m.)...Change of Condition: Situation: Resident found sitting in floor by her bed...Assessment: Dining staff notified nurse that resident lying on floor. This nurse entered room and resident sitting up in floor and yelling 'My head hurts, I'm dyeing" [sic]...Resident with raised are [sic] to mid lower back of head with moderate bleeding..."

"7/20/26 22:06 (10:06 p.m.) General Note: ...T/C (telephone call) from (Name) nurse at (hospital initials) stating xrays did not show any abnormal

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F 323	Continued From page 18 findings. Res (resident) had 5 staples put in head..." Care plan documentation included, "...7/21/16-Will place resident in low bed..." "8/3/2016 00:31 (12:31 a.m.)...Change of Condition: Situation: Resident found laying on back on floor at the end of residents bed..." Care plan documentation included, "...8/3/16-Will place Right side of bed against the wall so HOB (head of bed) is facing toward hallway, and will place landing strip to Left side of bed..." Review of facility fall investigation reports for May through August 2016 correlated with documentation in the clinical record regarding Resident #15. Fall investigation dated 06/22/2016 stated, "...After assessing resident, resident was brought into the dayroom so resident could be closely monitored...Resident has a history of falls. She has dementia and requires frequent cueing and redirection. Resident has poor vision and unsteady gait...Resident is not safe to ambulate unassisted but at times will get up out of bed and ambulate unassisted. Resident is located in semi-private room closest to nurses's station. Fall interventions reviewed and are appropriate at this time. Will educate staff to offer to toilet resident upon rising, ac, pc, and hs..." Fall investigation dated 07/20 2016 stated, "Upon investigation, resident was observed lying on the floor by dining staff who notified nursing...Resident examined and received staples to back of head and returned to the facility...Resident has a history of falls with appropriate interventions in place. Will place resident in a low bed..."	F 323		

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F 323	Continued From page 19 Fall investigation dated 08/02/2016 stated, "Upon investigation, resident found laying on back on floor at the end of residents bed...Resident wearing gripper socks at time of fall. Resident has dementia and will not ring for assistance. Will place Right side of bed against the wall so HOB facing toward hallway, and will place landing strip to Left side of bed..." The Administrator and DON (director of nursing) were informed of surveyor concerns regarding Resident #15's fall status during a meeting with the survey team on 11/02/2016 at approximately 3:45 p.m. Administrative staff was requested to present any information available concerning this resident's falls. On 11/03/2016 at approximately 8:00 a.m. the ADON (assistant director of nursing) entered the conference room to speak with this surveyor. The ADON stated, "We feel we did all we could for [Resident #15]. We kept her in the day room a lot of the time and moved her room closer to the nurses station so we could check on her often." When asked why alarms were not restarted on her readmission or thereafter the ADON stated, "When she first came back she wasn't very mobile so we didn't feel she needed alarms. We did something after each of her falls. You can see that here on the care plan." The Administrator and DON were informed of the above during a meeting with the survey team on 11/03/2016 at approximately 9:30 a.m. No further information was received prior to the exit conference 11/03/2016.	F 323		

F 323 Continued From page 20

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2. Resident #11 did not have interventions in place to prevent a fall with injury and resulting harm on 10/01/2016.

Findings were:

Resident #11 was most recently admitted to the facility on 09/21/2016 with the following diagnoses, but not limited to: Muscle weakness, congestive heart failure, dizziness and giddiness, and pancytopenia (deficiency of blood cells-red cells, white cells and platelets).

Resident #11 was assessed on his admission MDS (minimum data set), ARD (assessment reference date) 09/28/2016 and a significant change MDS, ARD 10/16/2016 as having a cognitive summary score of "08", indicating moderate impairment with his cognitive status.

Section "G"-Functional Status on the admission MDS included the following information:

G0110. Activities of Daily Living (ADL) Assistance
Transfer: Self Performance - Limited assistance (Resident highly involved in activity, staff provide guided maneuvering of limbs or other non-weight bearing assistance) Support: One person physical assist
Walk in Room: Self Performance - Limited assistance Support: One person physical assist
Walk in Corridor: Self Performance - Limited assistance Support: One person physical assist
Toilet use: Self Performance - Limited assistance Support: Two + persons physical

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F 323	Continued From page 21 assist G0300 Balance During Transitions and Walking Moving from seated to standing position: Not steady, only able to stabilize with staff assistance Walking (with assistive device if used): Not steady, only able to stabilize with staff assistance Turning around and facing the opposite direction while walking: Not steady, only able to stabilize with staff assistance Moving on and off toilet: Not steady, only able to stabilize with staff assistance Surface-to-surface transfer (transfer between bed and chair or wheelchair): Not steady, only able to stabilize with staff assistance Initial tour of the facility was conducted on 11/01/2016 at approximately 11:30 a.m. Resident #11 was observed sitting in a wheelchair at the nurse's station. He wore a blue helmet on his head and had blue bruising bilaterally around his eyes. The clinical record was reviewed on 11/02/2016. The following information was observed in the progress note section: "9/21/2016 Res [resident] admitted to facility...Ambulatory but unsteady. Alert with some confusion at times...Requires assistance of one for ADL's [activities of daily living], transfers and toileting...Res encouraged to use call light for assistance..." "9/22/2015 Res a/o [alert/oriented] with confusion at time [sic]...Transfers self without staff assistance and very unsteady. Staff encourages rs [resident] to use call light..."	F 323		

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F 323	Continued From page 22 "9/22/2016 Resident is alert with confusion...Requires assistance with ADLS. Can ambulate with supervision..."	F 323		

"9/23/2016 SBAR-Change of Condition Situation: Resident fell in room reaching in drawer for razor Background: History of Falls Assessment: No injury Response: Razor removed reminded to use call light and walker. Shoes placed on"

"9/23/2016 Rs a/o with confusion at time...Transfers self without staff assist and very unsteady. Staff encourages rs to use call light...up in hallway walking with walker high risk for falls post fall precautions at this time."

"9/24/2016 Resident A&O with confusion at time...Transfers self without staff assist and very unsteady. Staff encourages resident to use call light...Receiving therapy services for strengthening, ambulation, transferring, and personal hygiene..."
"9/25/2016 Resident A&O with confusion at time...Transfers self without staff assist and very unsteady. Staff encourages resident to use call light..."

"9/26/2016 Alert with confusion at times. receives skilled services for strengthening, ambulation, transferring and personal hygiene...Self transfers, unsteady. Ambulatory with rolling walker. Res. encouraged to use call light for assist..."

"09/27/2016 Alert with confusion...Receives skilled services for PT/OT [physical therapy/occupational therapy]. Requires assist of one with ADL's, supine to sit, sitting to stand

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position. Ambulatory with assist of rolling walker, Res. forgets to use walker at times and encouraged to use walker at all times. Res. unsteady at times..."

"9/27/2016 Physician Note Note Text: CC [Chief Complaint]: HX [History] FALLS/HEAD INJURY... Resident seen 09/27/2016 for follow-up evaluation s/p [status post] fall...He had multiple falls at home prior to hospital admission...HX FALLS hx frequent falls at risk for falls due to poor safety awareness continue to provide verbal and visual reminders to call for help..."

"09/28/2016 Resident A&O with confusion at time...Transfers self without staff assist and very unsteady. Staff encourages resident to use call light..."

"09/29/2016 Resident A&O with confusion at time...Transfers self without staff assist and very unsteady. Staff encourages resident to use call light..."

"09/29/2016 Physician Note ....HX FALLS hx frequent falls at risk for falls due to poor safety awareness continue to provide verbal and visual reminders to call for help..."

"09/30/2016 Weekly Care Management Meeting Current Functional Status in Therapy : CGA [contact guard assistance] Remaining Barriers (Performance with therapy): Cognitive/Safety Awareness Bed Mobility Transfers Walking Self Cares Toileting Bathing..."

"9/30/2016 ... Transfers self without staff assist and very unsteady. Staff encourages resident to use call light..."

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"10/02/2016 SBAR -Change of Condition Situation: Resident heard yelling "help" from room. Resident discovered on his back on the floor of his room just outside his bathroom by staff at 2200 [10:00 p.m.] Resident stated he got up to turn off his light. Background: MUSCLE WEAKNESS (GENERALIZED) 9/21/16 Primary Admission... Assessment: Resident laying on his back on the floor outside his bathroom. Large pool of blood noted underneath his head. Unable to assess laceration to the back of residents head related to concerns of head and neck trauma. Resident was alert and oriented. Able to answer questions appropriately. C/O [complained of] pain to right hip and head. Wheel chair found on left side of resident flipped over on front side. Walker at foot of the bed. Resident was barefoot... Response: Wife notified, 911 called and ER [emergency room] nurse [name] notified at 2205. Resident transported out of facility to the hospital via ambulance at 2218. Emergency room called for and update, Resident flown to Roanoke for further evaluation."

"10/4/2016 Late Entry Physician Note: Note Text: CC: HX FALLS/HEAD INJURY... Resident seen 10/04/2016 for reevaluation following return from hospital following fall in facility resulting in head injury. Resident was airlifted from [names of facilities] and had repair of arterial laceration and scalp closure....A/P [assessment and planning]: HX FALLS/HEAD INJURY hx frequent falls at risk for falls due to poor safety awareness nursing to cleanse and monitor scalp wound daily..."

The care plan was reviewed. A focus area, "At risk for falls related to: Use of medications that

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F 323	Continued From page 25 may cause dizziness, new environment, weakness, unsteadiness, hx [history] of falls, poor safety awareness at times, incontinence..." was observed with the goal "No fall related injuries" The focus area and the goal were initiated on 09/21/2016 at the time of Resident #11's admission. The following interventions for falls were implemented on 09/21/2016: "Call light or personal items available and in easy reach or provide reacher; Keep environment well lit and free of clutter; Observe for side effects of Medications; Orientation to new room and roommate; Therapy referral." On 09/26/2016 the following intervention was added: "Will place sign in room to remind resident to ring for assistance." Also observed on the care plan was a focus area, "I have a physical functioning deficit related to: Self care impairment, Mobility impairment..." Interventions listed included but were not limited to: "Transfer assistance of one", implemented 9/21/2016. On 11/02/2016 at approximately 3:00 p.m. the OT (occupational therapist) who had worked with Resident #11 was interviewed. She was asked what Resident #11's functional status was at the time of admission to the facility on 09/21/2016. She stated, "He needed assistance whenever he was up...we tried putting signs up in his room and did repeated cueing to remind him not to get up unassisted...he acted like he comprehended but he was like a toddler, he couldn't remember what you told him...He needed contact guard assistance whenever he was up." She was asked to review the PT notes. She stated, "PT evaluated him on 9/22/2016....he was moderate assistance for transfers, sit to stand, meaning he needed 50% assistance to transfer, he was minimal assistance, 25 % for transfers, stand to	F 323		

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F 323	Continued From page 26 pivot and walking on level surfaces." The OT was asked what that meant. She stated, "He shouldn't be up alone..he is a fall risk." She continued, "On 09/30 he was able to walk with someone beside him and he could do functional transfers with ques for safety." She was asked if he was safe for walking or transferring independently as of 09/30/2016. She stated, "No." The DON (director of nursing) was interviewed on 11/02/2016 at approximately 3:15 p.m., regarding Resident #11. Daily documentation regarding Resident #11 self transferring without staff assistance and being "Very unsteady" from the time of admission on 09/21/2016 until the time of fall with injury on 10/01/2016, was discussed. The DON was asked what interventions had been implemented to ensure Resident #11's safety prior to the fall with injury on 10/01/2016. She stated, "The company is moving away from alarms...he has one now but we are really trying not to use them." The DON was asked if any interventions other than the use of alarms were implemented prior to the fall with injury. She stated she would look. The DON presented a facility document "FALLS Events By Resident" on 11/02/2016. According to the document the only intervention implemented by the facility staff to ensure Resident #11's safety was to "place a sign in room to call for assist" on 09/23/2016. The DON was asked if any other interventions were implemented to address Resident #11's continued transfers without staff assistance. She shook her head from side to side, indicating "No." A meeting was held with the DON and the	F 323		

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F 323	Continued From page 27 administrator on 11/02/2016 at approximately 3:50 p.m. Concerns were voiced regarding Resident #11's fall on 10/01/2016 with resulting harm. The DON was asked for any additional information indicating precautions and interventions in place for Resident #11 to prevent falls prior to the fall with injury on 10/01/2016. On 11/03/2016 at approximately 8:30 a.m., the unit manager, RN (registered nurse) #4 came to the conference room to speak with this surveyor. No additional information was provided regarding new interventions that were put in place in response to Resident #11 transferring without assistance prior to his fall with injury on 10/01/2016. No further information was received prior to the exit conference on 11/03/2016. 3. Resident #5 suffered a burn on 09/19/2016 when she spilled hot coffee on her lap during lunch. Findings were: Resident #5 was most recently readmitted to the facility on 03/17/2016. Her diagnoses included but were not limited to: Dementia with behaviors, Type II Diabetes Mellitus, and pain. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/07/2016. Resident #5 was assessed as having a cognitive summary score of "06", indicating severe impairment with her cognitive status.	F 323		

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F 323	Continued From page 28 The clinical record was reviewed on 11/01/2016. The following notations were observed in the progress note section: "09/19/2016 Resident spilled coffee on pants during lunch. Resident left inner thigh pink and right inner thigh slightly pink. No blisters noted at this time. Will monitor area next few days." "09/21/2016 ...no redness noted to bilateral inner thighs (from 9/119 [sic] - coffee spill) ..." The physician order sheet was reviewed. An order was observed for "Adaptive Equipment: Lidded cups for all meals". The order was written on 07/01/2016. The DON (director of nursing) was asked on 11/02/2016 if there was an investigation regarding the burn that Resident #5 sustained on 09/19/2016. She stated she would see what she could find. The DON and the Dietary manager came to the conference room at approximately 9:30 a.m. on 11/02/2016. The DON stated, "She has an order for a lidded cup for all meals..." The DON and the dietary manager were asked if the lid had been in place at the time Resident #5 spilled her coffee and was burned. The DON stated, "I don't know...She has an order for it." The dietary manager was asked if the resident could spill her coffee with the lid on. The dietary manager stated, "It's possible." The DON informed this surveyor that no investigation had been done regarding the burn. The DON was asked if the lid had been in place on the cup when the burn occurred and who was in the dining room with the resident at the time it	F 323		

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F 323	Continued From page 29 happened. She stated, "I don't know...I know that there are staff in the dining room during meal times but I don't know what the circumstances were when she spilled the coffee." The DON was asked why Resident #5 had orders for a lidded cup. She stated, "It may be that she had spilled something in the past." No further information was obtained prior to the exit conference on 11/03/2016.	F 323		
	4. Resident #6 did not have wheelchair anti-tippers in use as required in her plan of care for fall prevention. Resident #6 was admitted to the facility on 3/13/14 with a re-admission on 11/11/15. Diagnoses for Resident #6 included chronic obstructive pulmonary disease (COPD), chronic kidney disease, cataracts, high blood pressure, dementia and osteoporosis. The minimum data set (MDS) dated 10/19/16 assessed Resident #6 with moderately impaired cognitive skills. Resident #6 was observed on 11/1/16 at 1:30 p.m. seated in her wheelchair in her room. The resident's wheelchair was missing an anti-tipper rod on the right side of her wheelchair. The left anti-tipper rod was not extended. This left anti-tipper did not extend beyond the circumference of the rear wheel and was approximately 4 to 5 inches from the floor. Resident #6 was observed again on 11/1/16 at 2:35 p.m. seated in her wheelchair with the missing right anti-tipper and short left anti-tipper rod.			

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Resident #6's plan of care (revised 8/30/16) listed the resident was at risk for falls due to medications, dementia, poor safety awareness and history of falls. The care plan listed the resident had falls on 1/25/16, 2/3/16, 6/27/16, 8/13/16 and 8/29/16. Care plan interventions to prevent falls included the use of "anti tippers" on the wheelchair to prevent the wheelchair from overturning.

On 11/1/16 at 2:40 p.m. accompanied by the licensed practical nurse (LPN #1), Resident #6 was observed in her wheelchair with the missing anti-tipper rod. LPN #1 was interviewed at this time about the missing right rod and the short left rod. LPN #1 stated, "She [Resident #6] is supposed to have both anti-tippers." LPN #1 stated she did not know why the right anti-tipper was missing. LPN #1 stated she would check with the maintenance director about the missing rod. LPN #1 stated the anti-tipper rods were designed to prevent the wheelchair from overturning if the resident attempted to get out of the chair.

On 11/1/16 at 4:15 p.m. was interviewed about the short anti-tipper rod mounted on the left side of the wheelchair. LPN #1 stated the left anti-tipper was "too short" and "won't do much good."

These findings were reviewed with the administrator and director of nursing during a meeting on 11/2/16 at 10:00 a.m.

F 323

F 329 SS=E 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

Each resident's drug regimen must be free from

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1. Resident #9 remains in the facility. Resident continues to receive Lorazepam 1 mg for anxiety and/or agitation daily PRN (as needed.)

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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.

This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, staff interview, and review of facility documents, the facility staff failed for one of 15 residents in the survey sample to ensure the resident was free of unnecessary medications. Resident # 9 was administered as needed Lorazepam as a prophylaxis without an assessment for the need of the medication at each administration.

The findings were:

Resident # 9 in the survey sample, a 91 year-old

F 329

2. All residents with a PRN (as needed) order for anxiolytic medications have the potential of being affected by this deficient practice. DNS/Designee will monitor all resident receiving anxiolytic medications. Any medications that are considered non-beneficial will be reviewed with Physician and/or Pharmacy Consultant for consideration of gradual drug reduction/discontinuation.
3. Physician was contacted requesting consideration for Resident #9 to have an order for Lorazepam gel to be applied topically 30 minutes prior to resident receiving shower and/or bed bath due to resident's increased anxiety/agitation during times of personal care. Order received from Physician and has been changed to reflect specific shower days and behavior/use for medication as of 11/22/16. The Care plan has been revised to state medication intervention will be considered when resident exhibits increased yelling, physically striking out at staff and prior to showers/baths.
4. DNS/Designee will monitor all orders for as needed anxiolytics for appropriate diagnosis and usage of the medication 5 times a week during morning start up over the next three (3) months to ensure the orders are current and accurate. Any medications that are considered non-beneficial will be reviewed with Physician and/or Pharmacy Consultant for consideration of gradual drug

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female, was admitted to the facility on 9/25/15 with diagnoses that included chronic obstructive pulmonary disease, anemia, asthma, pain, dementia with behavioral disturbances, and edema. According to the most recent Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/1/16, and the most recent Quarterly MDS with an ARD of 8/24/16, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with Summary Scores of 3 out of 15 and 4 out of 15 respectively.

Resident # 9 had the following physician's order, dated 4/23/16:

Lorazepam Tablet 1 mg (milligram). Give 1 mg by mouth as needed for anxiety and/or agitation QD (every day) PRN (as needed).

(NOTE: Lorazepam (Ativan) is a short acting benzodiazepine used to treat anxiety and irritability with psychiatric or organic disorders. Given orally, it has an onset of one hour with a peak of two hours. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 722.)

Review of the Electronic Medication Administration Record (EMAR) for the months of September, October, and November 2016 revealed the resident was administered as needed Lorazepam seven times between 9/7/16 and 11/2/16.

The following Progress (Nurses) Notes, found in Resident # 9's electronic clinical record, coincided with the administration of the as needed Lorazepam documented on the EMAR's for the months of September, October and November

F 329

reduction/discontinuation. Results will be taken to QAPI monthly for review and recommendations for three (3) months, with the QAPI Committee responsible for on-going compliance.

5. Corrective action will be completed by December 12, 2016.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495168		C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-SHENANDOAH VALLEY	3737 CATALPA AVE, PO BOX 711 BUENA VISTA, VA 24416

(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 329	Continued From page 33 2016, as well as with the showers/full bed baths for the resident documented on the Bathing Type Detail Reports: 9/14/16: 10:20 a.m. "Lorazepam Tablet 1 mg. Give 1 mg by mouth as needed for anxiety and/or agitation QD PRN. Given prior to shower for agitation.: 11:43 a.m. "PRN administration was: Ineffective. Resident continues to yell and combative in shower room." 9/21/16: 8:26 a.m. "Lorazepam Tablet 1 mg. Give 1 mg by mouth as needed for anxiety and/or agitation QD PRN. Given for anxiety before shower." 11:44 a.m. "PRN administration was: Effective, helped." 9/28/16: 10:34 a.m. "Lorazepam Tablet 1 mg. Give 1 mg by mouth as needed for anxiety and/or agitation QD PRN." 2.30 p.m. "Lorazepam Tablet 1 mg. Give 1 mg by mouth as needed for anxiety and/or agitation QD PRN. PRN administration was: Effective." 10/5/16: 8:29 a.m. "Lorazepam Tablet 1 mg. Give 1 mg by mouth as needed for anxiety and/or agitation QD PRN. Given to help during bath time." 10:55 a.m. "Lorazepam Tablet 1 mg. Give 1 mg by mouth as needed for anxiety and/or agitation QD PRN. PRN administration was: Effective helped." 10/12/19: 9:30 a.m. "Lorazepam Tablet 1 mg. Give 1 mg by mouth as needed for anxiety and/or agitation	F 329		

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F 329 Continued From page 34

QD PRN. Given for agitation before bath."
12:16 p.m. "PRN administration was: Effective helps."

10/19/16:
9:45 a.m. "Lorazepam Tablet 1 mg. Give 1 mg by mouth as needed for anxiety and/or agitation QD PRN. Given before her bath."
12:03 p.m. "PRN administration was: Effective helped."

11/2/16 - 12:29 p.m. "Lorazepam Tablet 1 mg. Give 1 mg by mouth as needed for anxiety and/or agitation QD PRN. Given to resident before her shower."

At approximately 11:20 a.m. on 11/2/16, CNA # 1 (Certified Nursing Assistant) was interviewed regarding Resident # 9. CNA # 1 identified herself as one of the two member bathing team. Asked about the administration of Lorazepam to the resident before her showers, CNA # 1 said, "We know she gets medicated, but we don't know when. The medication does not always work. She still claws and scratches us. She has her good days and bad."

CNA # 1 was also asked if it made a difference when during the day Resident # 9 was bathed. "The time of day makes no difference," she said. Asked if there was a difference in the resident's behavior between a shower or a bed bath, CNA # 1 said, "She is a little better with a bed bath, but her family wants her to have a shower."

At 1:50 p.m. on 11/2/16, CNA # 1 was observed moving Resident # 9 back into her room after a shower. The resident was on a shower gurney and was dressed in street clothes. Asked how

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NAME OF PROVIDER OR SUPPLIER: GOLDEN LIVINGCENTER-SHENANDOAH VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE: 3737 CATALPA AVE, PO BOX 711 BUENA VISTA, VA 24416	

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F 329	Continued From page 35 the resident was during her shower, CNA # 1 responded, "She was not good today. The medication was not effective." A thorough review of Resident # 9's electronic clinical record and her paper clinical record failed to reveal any documentation to indicate the resident was being assessed for anxiety or agitation prior to the administration of the as needed Lorazepam at bath time. The findings were addressed during an end of day meeting at 4:00 p.m. on 11/2/16 that included the Administrator, Director of Nursing, Assistant Director of Nursing, and the survey team. The administrative team offered no explanation when the survey team expressed concerns that without an assessment prior to bathing, the use of the Lorazepam was a prophylaxis in anticipation of the resident's resistive and combative behaviors. The survey team also noted that on at least two occasions, 9/14/16 and 11/2/16, the Lorazepam was not effective.	F 329		
F 332 SS=D	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 by: Based on medication pass and pour observation, clinical record review and staff interview, the facility staff failed to ensure a medication error rate less than five percent.	F 332	1. Resident #5 remains in the facility. Physician was notified of medication error. Resident without adverse outcome. Identified nurse and education on medication administration guidelines was completed. 2. All residents receiving medications could have the potential of being affected by this deficient practice. DNS/Designee will conduct medication pass observation weekly to assure medications are being administered per physician order over the next three months. 3. Licensed nurses will be educated on the five rights of administration.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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A medication pass and pour observation conducted on 11/02/2016 resulted in a medication error rate of 5.40%. A total of 37 opportunities were observed with two errors identified.

Findings were:

A medication pass and pour observation was conducted on 11/02/2016 beginning at 8:00 a.m. with RN (registered nurse) #2.

RN #2 was observed giving medication to Resident #5.

Resident #5 was most recently readmitted to the facility on 03/17/2016. Her diagnoses included but were not limited to: Dementia with behaviors, Type II Diabetes Mellitus, and pain.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/07/2016. Resident #5 was assessed as having a cognitive summary score of "06", indicating severe impairment with her cognitive status.

RN #2 prepared the following medications for administration to Resident #5: Aspirin 325 mg (milligrams), Aspirin 81 mg, Colace 100 mg, a multivitamin with minerals, Vitamin D 400 mg, and Vitamin E 400 mg.

After the medications were prepared and administered the clinical record was reviewed for medication reconciliation. There was no order within the clinical record for Aspirin 325 mg to be administered. There was an order for Tylenol 325 mg, "Give 650 mg [two tablets] by mouth three times a day for pain". The Tylenol was scheduled

F 332

4. DNS/Designee will conduct medication pass observation weekly to assure medications are being administered per physician order over the next three months. Results will be taken to QAPI monthly for review and recommendations for the three months, with the QAPI committee responsible for on-going compliance.
5. Corrective action will be completed by completed December 12, 2016.

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F 332 Continued From page 37

to be administered at 8:00 a.m. The Tylenol was not observed during the medication pass. The MAR (medication administration record) was then reviewed in the electronic record. The scheduled Tylenol was checked off as having been given with the 8:00 a.m. medications.

This surveyor returned to the medication cart to speak with RN #2 at approximately 8:45 a.m. RN #2 was asked about the 325 mg dosage of Aspirin administered to Resident #5. RN #2 reviewed the computer screen used to administer medications. She stated, "I gave her 325 mg of Aspirin instead of the Tylenol. I didn't give the Tylenol at all and I signed it off. I will notify the physician.

The unit manager spoke with this surveyor at approximately 9:30 a.m. She stated, "We contacted the physician, we aren't going to give the morning dose of Tylenol since she got the aspirin. There were no other orders."

The DON (director of nursing) and the administrator were notified of the 5.40% medication error rate during a morning meeting on 11/02/2016 at approximately 10:00 a.m.

No further information was obtained prior to the exit conference on 11/03/2016.

F 332

F 425 SS=D 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State

F 425 1. Resident #2 remains in the facility. Physician was notified of omission of medication. Resident without adverse outcome. Identified nurse received education to medication availability and notification requirements. Resident continues to have an order for Nifedipine 1 tab PO BID.

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F 425 Continued From page 38

law permits, but only under the general supervision of a licensed nurse.

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.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure medications were available for administration for one of 15 residents in the survey sample.

Resident #2 missed two consecutive doses of the blood pressure medication Nifedipine because the medication was not available from the pharmacy.

The findings include:

Resident #2 was admitted to the facility on 8/20/15 with diagnoses that included high blood pressure, diabetes, chronic obstructive pulmonary disease (COPD), depression, heart failure and chronic pain. The minimum data set (MDS) dated 10/19/16 assessed Resident #2 with moderately impaired cognitive skills.

F 425

2. All residents receiving medications could have the potential of being affected by this deficient practice. DNS/Designee will complete a medication omission review and address identified concerns as indicated.
3. Licensed nurses will be educated on timely reordering of residents' medications and to notify physician when medication is not available.
4. Results will be taken to QAPI monthly for review and recommendations for three months, with the QAPI committee responsible for on-going compliance.
5. Corrective action will be completed by completed December 12, 2016.

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Resident #2's clinical record documented a physician's order dated 8/20/15 for the medication Nifedipine 30 mg (milligrams) to be administered twice per day for the treatment of high blood pressure. Resident #2's medication administration record (MAR) for October 2016 documented the resident missed the 9:00 p.m. dose of Nifedipine on 10/15/16 and missed the 9:00 a.m. dose on 10/16/16. A nursing note dated 10/15/16 at 9:37 p.m. documented concerning the missed Nifedipine "awaiting pharmacy..." A note dated 10/16/16 at 6:07 p.m. documented, "Received written order to hold AM [morning] dose- med not available..." Another nursing note dated 10/16/16 at 7:43 p.m. stated, "Resident has a current order for nifedipine...This medication was unavailable this am [morning]..."

On 11/2/16 at 9:10 a.m. the licensed practical nurse (LPN #1) caring for Resident #2 was interviewed about the unavailable Nifedipine on 10/15/16 and 10/16/16. LPN #1 stated nurses were supposed to reorder medications from the pharmacy before they ran out. LPN #1 stated the medications had a reorder date printed on the label. LPN #1 stated after this date the stickers were removed from the medication cards and faxed to the pharmacy for refills. Concerning the unavailable Nifedipine for Resident #2, LPN #1 stated the medication was probably not reordered in time. LPN #1 stated the Nifedipine was not in the emergency supply kept at the facility and had to come from the pharmacy.

These findings were reviewed with the administrator and director of nursing during a meeting on 11/2/16 at 3:45 p.m.

F 425

F 502 483.75(j)(1) ADMINISTRATION

F 502

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 502 SS=D

Continued From page 40

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 and clinical record review, facility staff failed to obtain a physician ordered lab test for one of 15 residents in the survey sample, Resident #4.

Facility staff failed to obtain a CMP (comprehensive metabolic panel) during the month of August 2016 as ordered by the physician.

Findings included:

Resident #4 was admitted to the facility on 06/17/2015 with diagnoses including, but not limited to: Dementia with Behaviors, Hypertension, Atrial Fibrillation, Anxiety and Iron Deficiency Anemia.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/07/2016. Resident #4 was assessed as severely impaired in cognitive status with a total cognitive score of one out of 15.

Resident #4's clinical record was reviewed 11/01/2016 at 1:50 p.m. The current POS (physician order sheet) dated November 2016 included the following order: "...Labs: ...CMP...q6 months (every six months) Order Date: 02/24/2016, Start Date: 02/24/2016..." No

F 502

1. Resident #4 remains in the facility. Resident had CMP obtained on day of survey. Resident continues to have order for labs every six months.
2. All residents with orders for lab tests could have the potential of being affected by this deficient practice. DNS/Designee will review all labs obtained each day and compare to physician orders for accuracy. Lab tests will be monitored five days a week.
3. All nursing staff will be educated on Laboratory guidelines to accurately record lab tests to be drawn onto lab order sheet.
4. DNS/Designee will review all labs obtained each day and compare to physician orders for accuracy. Lab tests will be monitored five days a week. Results will be taken to QAPI monthly for review and recommendations for three months, the QAPI committee will be responsible for on-going compliance.
5. Corrective action will be completed by completed December 12, 2016.

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F 502	Continued From page 41 lab results for a CMP during August 2016 were located in the clinical record. The ADON (assistant director of nursing) was interviewed 11/02/2016 at approximately 7:30 a.m. regarding the CMP lab result. The ADON stated, "Let me look into it and I will get back with you." At approximately 8:42 a.m. the ADON approached the conference room and stated, "It (meaning CMP) wasn't on the lab slip and wasn't drawn." The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 11/02/2016 at approximately 10:00 a.m. No further information was received by the survey team prior to the exit conference on 11/03/2016.	F 502		