STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495087	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM HEALTH & REHABILITATION	1945 ROANOKE BLVD SALEM, VA 24153

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 05/23/17 through 05/25/17. Two complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 240 certified bed facility was 225 at the time of the survey. The survey sample consisted of 27 current Resident reviews (Residents #1 through #27) and 4 closed record reviews (Residents #28 through #31).

F 155 SS=D	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES	F 155		7/3/17

483.10
(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).

(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/26/2017

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(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.

(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.

(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.

(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

483.24
(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure mechanism for documenting and communicating the resident's choice to staff related to a DDNR (Durable Do Not Resuscitate)

The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and

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F 155	Continued From page 2	F 155		

for 1 of 31 Residents, Resident #29.

The findings include:

The clinical record of Resident #29 was reviewed 5/23/17 through 5/25/17. Resident #29 was admitted to the facility on 5/08/16 with diagnoses that included but not limited to: high blood pressure, diabetes mellitus, anxiety, respiratory failure, and heart failure. Resident #29 expired at the facility on 10/7/16.

A review of Resident #29's clinical record revealed on the quarterly minimum data set (MDS), with an assessment reference date of 7/19/16. Section C (cognitive patterns) of this assessment scored the resident a 15 indicating the resident was cognitively intact. Section B coded the resident to understand and to be understood.

Resident #29's comprehensive care plan with a created date of 06/11/16 and a revised date of 10/7/16, did not include in the comprehensive care plan her code status; a full code or a do not resuscitate. Her code status was not on the care plan.

Further review of the clinical record revealed, the durable do not resuscitate order form filled out completely and correctly. The valid form was dated 10/5/17.

The physician's summary of orders was reviewed on 5/25/17 to evidence the documentation of both the full code and DDNR status for the resident. There was no clear written communication on the document of the accuracy of the resident's status. No other written order was provided to the

federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.

F155
1. Resident #29 s DDNR form is accurate and present in the clinical record.

2. Current residents with MD orders for DNR will be reviewed to ensure DDNR forms are present in the clinical record. Corrections will be made immediately as indicated.

3. Current licensed nursing staff and medical records staff will be educated regarding placement of DDNR forms in clinical record. Medical records staff will review new admissions weekly x 6 weeks for DNR orders and ensure placement of DDNR in the clinical record.

4. Process will be reviewed in QA committee for two quarters.

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F 155	Continued From page 3 surveyor. During an interview on 5/25/17 at 7:45 am, with LPN #4 the surveyor was informed that the resident was coded by the staff and the emergency medical team when they arrived at the facility, because the DDNR form had not been placed in the clinical record. LPN #4 was not made aware of the change in status. At 8:30 am, an interview with the director of nurses confirmed the resident had been coded because the DDNR form had not been placed in the clinical record. On 5/25/17 during a meeting with the administration staff that included the administrator, the director of nurses, the assistant director of nurses, and the regional nurse consultant the aforementioned was disused. No further information was provided to the surveyor related the DDNR status prior to exit.	F 155		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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	F 226		7/3/17

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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F 226	Continued From page 4 (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 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 and clinical record review, facility staff failed to report the incident regarding the lack of supervision the resident received to safeguard from harm for 1 of 30 residents in the survey sample (Resident #30). The findings included. Resident #30 was admitted to the facility on 2/13/17 with diagnoses including zoster with complications, dementia without behavior ; hypertension, and benign prostatic hypertrophy. On the admission Minimum Data Set assessment with assessment reference date 2/20/17, the resident scored 5/15 on the Brief Interview for Mental Status. The resident was assessed as without symptoms of delirium, psychosis, or	F 226	F226 1. Resident 30 s elopement incident was reported to the State Survey Agency on (need to add date). 2. Current residents with incidents/accidents occurring in the last 30 days will be reviewed to ensure that if any incidents/accidents required reporting to State Survey Agency, that reporting was done timely. 3. The Administrator will adhere to reporting requirements as indicated when an incident/accident is reported. Incidents will be reviewed daily 5 X week X 6 weeks by administration and nursing leadership to ensure timely reporting as applicable. Any issues will be addressed immediately	

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behaviors affecting self or others, including wandering.

During clinical record review on 5/24/17, the surveyor noted there was no mention of an incident reported to the office of licensure and certification. The report stated that the resident exited the facility on 2/16/17 and returned with injuries. A followup report indicated that the resident was "transferred to a locked unit" and the employee involved "terminated 2/21".

The resident's clinical record contained no entries, other than medication administration entries, from 2/14/17 at 13:02 until 2/17/17 at 05:16. The clinical record did not document the resident's status for 48 hours prior to the elopement or physical status on his return to the facility.

The resident's Treatment Administration Record for 2/1/17-2/28/07 documented an order dated 2/16/17 at 20:07 "May apply wanderguard, take resident to door and check q shift every shift" This order was documented as completed with a check mark and staff initials each shift from night shift on 2/16/17 through day shift on 2/22/17 except for except for evening shift on 2/18/17 and night shift on 2/20/27. No explanation was given for the omissions on those dates. No documentation was available to explain the actions which led to the placement of the wanderguard. No nursing or physician notes documented any behaviors prior to 2/17/17.

The clinical record documented X-ray results from Dynamic Mobile Imaging on 2/17/17 for "facial bones, less than 3 views","right hand, 3+views", and "left hand, 3+views". The clinical

at the time of identification.
4. Process will be reviewed in QA committee for two quarters.

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record did not document symptoms for which the three diagnostic tests were ordered.

The clinical record contained no physician note after admission. A discharge planning note documented informing the family that the resident required a memory care unit. There is no record of a physician level assessment concerning the requirement for a transfer to a higher level of care.

The surveyor discussed concerns about the cause of the elopement, the lack of documentation, and safety of other residents who might wander with the administrator and director of nursing on 5/24/17. The administrator reported that on the 16th (of February 2017), the patient "started moving around" and the wanderguard was placed. At 6:21 PM, the patient was not located in the building. At 6:21, the facility received a call that the resident had been spotted on Hemlock Dr. The administrator drove around the area and found the resident and returned him to the facility at 6:52 PM. The administrator and director of nursing conducted staff interviews. A CNA reported walking the resident to his room on unit 4 and returning to unit 1 and silencing the alarm for the wanderguard. The CNA was later terminated for failing to check that the resident was in his room before silencing the alarm.

The surveyor reported to the administrator and director of nursing concern that the wandering, placement of the wanderguard, elopement and later determination, reported in the facility reported event followup report, of the need for 15 minute checks did not appear in the clinical record. Physical assessment of the resident's status was documented as occurring on 2/17/17

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F 226	Continued From page 7 at 8:22 AM, more than 12 hours after the resident's return to the facility with apparent injuries to the face and hands. The surveyor was also concerned that staff did not document checking the functionality of the wanderguard on 2 separate shifts after the elopement. No nursing progress notes were documented for those 2 shifts.	F 226		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate 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	F 278		7/3/17

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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 a complete and accurate Minimum Data set (MDS) for 1 of 31 residents (Resident #6).

The findings include:

The facility staff failed to ensure the significant change MDS with a reference date of 1/25/17 was complete and accurate for Resident #6.

Resident #6 was re-admitted to the facility on 1/18/17 with diagnoses of glaucoma, gastroesophageal reflux disease, dementia, 7th cervical vertebra fracture, anemia, peripheral vascular disease, hypertension, pneumonia, and malnutrition.

The significant change MDS with a reference date of 1/25/17 assessed the resident requiring extensive assistance of 1 person for bed mobility, transfers, ambulation, dressing, toileting, bathing, and hygiene.

The facility staff failed to assess the cognitive and decision making ability of the the resident in Section "C" for "Cognitive Patterns". The facility staff placed dashes (-) in the section. The facility staff also failed to complete Section "D" for "Mood" for Resident #6 and again placed dashes(-) in the area for both resident and staff

F278
1. Resident # 6 s MDS was modified to include accurate documentation for cognitive/decision making ability in Section C, mood in Section D, and diagnoses of GERD/glaucoma in section I.
2. MDS Coordinators will review current residents MDS assessments for section C, D, and I to ensure accuracy of coding. Any issues will be addressed immediately at the time of identification.
3. MDS coordinators will be educated regarding section C, D, and I coding. MDS coordinators will alert nursing administration and discharge planning weekly X 6 weeks when a resident s MDS assessment is completed by providing section C, D, and I for verification of accuracy of coding.
4. Process will be reviewed in QA committee for two quarters.

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F 278	Continued From page 9 assessment of mood. Section "I" "Active Diagnoses" was also reviewed. The facility staff failed to include the diagnoses of glaucoma and gastro-esophageal reflux disease (GERD) for which the resident was receiving medications. The MDS coordinator was interviewed on 5/24/17 at 9:00 a.m. The incomplete MDS was reviewed and the coordinator stated the areas were missed. The administrator, director of nursing, assistant director of nursing, and corporate nurse consultant were informed of the findings during an end of the day meeting with the survey team on 5/24/17 at 4:00 p.m.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 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 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	F 279		7/3/17

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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.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the

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requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to develop a comprehensive plan of care for 1 of 30 residents, Resident #29.

The findings include:

For Resident #29, the facility staff failed to develop a comprehensive care plan to indicate if she was a full code or a DDNR (Durable Do Not Resuscitate) status.

The clinical record of Resident #29 was reviewed 5/23/17 through 5/25/17. Resident #29 was admitted to the facility on 5/08/16 with diagnoses that included but not limited to: high blood pressure, diabetes mellitus, anxiety, respiratory failure, and heart failure. Resident #29 expired at the facility on 10/7/16.

A review of Resident #29's clinical record revealed on the quarterly minimum data set (MDS), with an assessment reference date of 7/19/16. Section C (cognitive patterns) of this assessment scored the resident as a 15 indicating the resident was cognitively intact. Section B coded the resident to understand and to be understood.

Resident #29's comprehensive care plan with a created date of 06/11/16 and a revised date of 10/7/16, did not include in the comprehensive care plan her code status; a full code or a do not resuscitate. Her code status was not on the care

F279
1. Resident #29's care plan was corrected to address DNR status.
2. Nursing leadership will review current residents with MD orders for DNR. Care plans will be corrected immediately as indicated.
3. Current licensed nursing staff will be educated regarding developing comprehensive care plans to meet the active care needs of the residents including DNR status. Licensed nursing staff will make daily updates to care plans as applicable. Unit managers or designees will review care plans weekly X 6 weeks based on MDS assessment schedule to ensure accuracy of the care plan for DNR. Any issues will be addressed immediately at the time of identification.
4. Process will be reviewed in QA committee for two quarters.

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F 279	Continued From page 12 plan. Further review of the clinical record revealed, the durable do not resuscitate order form filled out completely and correctly. The valid form was dated 10/5/17. The physician's summary of orders reviewed on 5/25/17, evidenced documentation of both the full code and DDNR status for the resident. There was no clear written communication on the document of the accuracy of the resident's status. No other written order was provided to the surveyor. On 5/25/17 during a meeting with the administration staff that included the administrator, the director of nurses, the assistant director of nurses and the regional nurse consultant, the care plan not including the code status was disused. No further information was provided to the related the care plan prior to exit.	F 279		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed	F 281	F281 1. Resident #11: s current nurse	7/3/17

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to follow professional standards of nursing regarding documentation for 1 of 31 residents in the survey sample (Resident #11).

The findings included:

Resident #11 was readmitted to the facility on 2/18/17 with the following diagnoses of, but not limited to high blood pressure, arthritis, dementia, seizure disorder, manic depression, Schizophrenia, dysphagia and muscle weakness. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/9/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 9 out of a possible score of 15. Resident #11 was also coded as requiring extensive assistance of 1 staff member for dressing, transfers and totally dependent on 1 staff member for bathing.

The surveyor performed a review of Resident #11's clinical record on 5/24/17. The surveyor also observed Resident #11 in her room on 5/24/17 at 8:25 am and it was observed that the resident had an IV (intravenously) solution of 1 liter 0.45% NS (Normal Saline) at 62.5 ml/h (milliliter per hour) was infusing. The surveyor reviewed the nursing notes for 5/23/17 and 5/24/17 and noted that there was no nursing documentation of the above mentioned IV ever being inserted or started on resident in the nursing notes or on the resident's Medication Administration Record (MAR). The surveyor interviewed the director of nursing (DON) on 5/24/17 at 10:30 am in the conference room and the surveyor asked when the IV was inserted or started on Resident #11. The DON reviewed the nursing documentation on the laptop with the surveyor. The DON stated "By this, there is no

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progress notes to indicate the start time of intravenous fluids, were recorded via late entry on (need date and time).
2. Current residents receiving intravenous fluids were reviewed to determine accurate documentation of infusion time and status. Corrections were made immediately as indicated.
3. Licensed nursing staff were educated regarding accurate documentation of intravenous fluid infusion times and status. Nursing leadership will review shift reports daily 5X weekly X6 weeks to ensure intravenous fluid documentation is present and accurate. Any issues will be addressed immediately at the time of identification.
4. Process will be reviewed in QA committee for two quarters.

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documentation to tell me when this was started." The DON and surveyor also reviewed the documentation on the resident's MAR for 5/23/17 and 5/24/17. The only documentation found on the MAR was initials under the evening portion for 5/24/17 for the IV administration but no time was listed. The surveyor asked the DON what was the expectation of the nursing staff when an IV was started. The DON stated "The nurses should write a nursing note of the time and date in which it was started, but this nurse did not do that. She left her shift and no one here knows when it was started." The surveyor asked the DON what time the IV was started on Resident #11 and the DON stated "I don't know but I will look into it and let you know." The surveyor asked the DON for a copy of the standards of nursing documentation in which she would hold her staff accountable for in this situation.

At approximately 5 pm on 5/24/17 in the conference room, Licensed Practical Nurse (LPN) #2 was interviewed by the surveyor. The surveyor and LPN #2 went into the electronic medical record and reviewed the nursing documentation concerning the starting of the IV on Resident #11. The following documentation was noted by the surveyor that had not been in the electronic clinical record at 10:30 am when it was reviewed with the DON:
"5/24/17 00:39 (12:39 am) ...nurse attempted multiple times to place IV and was not successful. Called MD (Medical Doctor) and got order for hemodermoclysis subcutaneous infusion X (times) 2 bags with change sites for each bag ...5/24/17 05:41 (5:41 am) monitored hemodermoclysis subcutaneous infusion during shift rsd (resident) tolerated well @ 62.5 ml/hr. no swelling or edema, no adverse reactions at

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this time ..."

The surveyor asked LPN #2 when this documentation had been documented in the electronic clinical record and LPN #2 stated "I did it when I came back into work this afternoon just about 30 minutes ago."

The surveyor, DON and Administrator met in the conference room and the surveyor showed the administrative team the documentation that was present in the clinical record at this time. The DON stated "That was not in there when you and I looked at it this morning. I left her a message and told her that she had to document when the IV was started on this resident when she came into work this afternoon."

At 6:20 pm, The DON returned with a policy titled "Nursing Documentation" which the DON stated that this policy was used as the standard of practice that the facility uses. The policy stated the following:
"Licensed Nurses and CNAs (Certified Nurses Assistants) will document all pertinent nursing assessments, care interventions, and follow up actions in the medical record.
...16. ...Complete the note as soon as possible after the original entry ...
...18. Every change in the patient's condition or significant patient care issues will be noted and charted until the condition is resolved or stabilized. Documentation that provides evidence of follow-through is resolved or stabilized ..."
The administrative team was notified of the above documented findings on 5/25/17 prior to the exit conference.

No further information was provided to the

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F 281	Continued From page 16 surveyor prior to the exit conference on 5/25/17.	F 281		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		7/3/17

483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

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This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure the highest practicable well-being for 6 of 31 Residents, Residents #31, #17, #4, #13, #20 and #24.

The findings included.

1. For Resident #31, the facility staff failed to administer the physician ordered seizure medication vimpat on 03/04/17 at 9:00 a.m.

The clinical record review revealed that Resident #31 had been admitted to the facility 07/23/14. Diagnoses included, but were not limited to, epilepsy, intellectual disabilities, gastroesophageal reflux disease, anxiety, neuropathy, and hemiplegia.

The Resident had been discharged on 04/07/17.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/16/16 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section I (active diagnoses) was coded to indicate the Resident had an active diagnosis of "seizure disorder or epilepsy."

The Residents CCP (comprehensive care plan) included the focus area of seizure disorder. Interventions included, but were not limited to, give medications as ordered and observe for seizure activity.

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1. Resident #31 no longer resides in the facility. MD was notified for omeprazole not given as ordered for Resident #17 and order was clarified; Resident is currently receiving medication as ordered. MD was notified for Resident #4 s omitted Clindamycin dose on 5/8/17; no new orders received. Dialysis communication forms are currently complete and accurate for Residents #13 and #20. MD was notified that Resident #24 received Albuterol instead of Duo-Neb medication as ordered; no new orders received and Resident is currently receiving medication as ordered.

2. Current Residents Medication Administration Records (MAR) will be reviewed to ensure doses are being administered as ordered by MD. Current residents receiving dialysis will be reviewed to ensure communication forms are complete and present in the clinical record.

3. Nursing staff were educated regarding accurate administration of medications per MD orders and accurate completion of dialysis communication forms. Unit managers and/or designees will review MAR reports daily 5X week X 6 weeks to ensure doses are being given as ordered by MD and will review residents receiving dialysis 2X week X 6 weeks to ensure communication forms are complete. Any

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The Residents clinical record included an order for the seizure medication vimpat every 12 hours for seizures. The administration times on the eMAR (electronic medication administration record) were documented as 0900 (9:00 a.m.) and 2100 (9:00 p.m.).

A review of the Residents eMARs for February and March 2017 indicated that the facility nursing staff had not documented on numerous occasions that the Residents medications had been administered.

A review of the Residents narcotic sheets revealed that the nursing staff had removed 1 tablet of vimpat on 03/03/17 at 2100 and on 03/04/17 at 2100. There was no documentation to indicate the medication had been removed at 0900 on 03/04/17. A review of the eMAR revealed that the administration block for this medication had also been left blank on 03/04/17 at 0900.

The administrative staff was notified of the above in a meeting with the survey team on 05/25/17 at 10:45 a.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. The facility staff failed to follow the physician's order concerning the administration of Omprazole to Resident #17.

Resident #17 was readmitted to the facility on 2/14/17 with the following diagnoses of, but not limited to high blood pressure, ulcerative colitis, arthritis, dementia, seizure disorder, manic depression, GERD and Schizophrenia. On the annual MDS (Minimum Data Set) with an ARD

issues will be addressed immediately at the time of identification.

4. Process will be reviewed in QA committee for two quarters.

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(Assessment Reference Date) of 5/9/17 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 9 out of a possible score of 15. The resident requires extensive assistance of 1 staff member for dressing, eating and personal hygiene.

The surveyor performed a clinical record review on 5/24/17. It was noted by the surveyor that Resident #17 had the following physician order on the MAR (Medication Administration Record) for the month of May, 2017 which stated: "Omprazole Tablet Delayed Release 20 mg (milligram) Give 20 mg by mouth one time a day for GERD. Give at least 30 minutes before a meal."

According to the documentation on the MAR for 5/24/17, the above documented medication was administrated to the resident at 0900 (9:00 am). The surveyor observed the resident having her breakfast tray being set up by the CNA (Certified Nurses' Assistant) at 8:35 am then the resident was observed to begin eating her breakfast after that time by the surveyor.

The administrative team was notified of the above documented findings on 5/24/17 at 3:25 pm in the conference room by the surveyor.

No further information was provided to the surveyor prior to the exit conference on 5/25/17.
3. The facility staff failed to administer medications as ordered by the physician for Resident #4.

The facility staff failed to administer Clindamycin 150 mg (milligram) capsule on 5/8/17 at 0600 to Resident #4.

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The clinical record of Resident #4 was reviewed 5/23/17 and 5/24/17. Resident #4 was admitted to the facility 9/25/15 and readmitted 1/1/17 with diagnoses that included but not limited to gastrointestinal hemorrhage, colon cancer with colostomy, depressive disorder, atrial fibrillation, gangrene, anxiety, malnutrition, chronic diastolic congestive heart failure, peripheral vascular disease, hypertension, and traumatic amputation of right lesser toe.

Resident #4's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/6/17 assessed the resident with a cognitive summary score of 9 out of 15 and without signs or symptoms of delirium, psychosis or behaviors that affected others.

A verbal order dated 5/1/17 23:08 (11:08 p.m.) for Resident #4 read "Clindamycin HCL Capsule 150 mg Give 150 mg by mouth every 6 hours for infection for 7 days."

The May 2017 electronic medication administration record (eMAR) was reviewed. The entry for 5/8/17 at 0600 was blank. There were no progress notes for 5/8/17 in the clinical record why the medication had not been administered.

The surveyor informed the corporate registered nurse of the above concern on 5/24/17 at 10:15 a.m. and stated she saw where the medication had been missed and stated there was no documentation pertaining to why the medication had not been administered in the progress notes.

The surveyor informed the administrative staff of the above concern in the end of the day meeting

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No further information was provided prior to the exit conference on 5/25/17.

4. The facility staff failed to coordinate care between the dialysis center and the facility for Resident #13.

The clinical record of Resident #13 was reviewed 5/23/17 and 5/24/17. Resident #13 was admitted to the facility 12/6/13 with diagnoses that included but not limited to end stage renal disease, hypotension, dementia without behavioral disturbances, type 2 diabetes mellitus, dysphagia, and hyperlipidemia.

Resident #13's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/28/17 assessed the resident with a cognitive summary score of 11. Resident #13 required limited assistance of staff members to accomplish all ADLs (activities of daily living.) The resident was frequently incontinent of bowel and bladder. Under special treatments, Resident #13 was coded for dialysis.

Resident #13's current comprehensive care plan was revised on 10/19/16. The plan included chronic renal failure r/t (related to) end stage disease and receives hemodialysis 3 times weekly. Goal was to have no signs or symptoms of complications related to fluid overload and to maintain normal weight.

Resident #13 had physician's order for dialysis three times a week and orders to monitor shunt for bruit and thrill every shift per protocol.

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The dialysis communication sheets used to share the flow of information between the facility and dialysis (three days a week) were reviewed from 10/1/16 through 5/24/17. The dialysis form had three sections to be completed. Section A. Pre-Dialysis (to be completed by Health and Rehab Center). Section B: Dialysis (to be completed by Dialysis Center). Section C: Post-Dialysis (to be completed by Health and Rehab Center). Upon return to the Health and Rehab Center, please document the following: Vital Signs, Assessment of Dialysis Site/AV Fistula (dressing, drainage, bruit, thrill, distal pulse), Pre and Post Dialysis Weights and Skin Assessment Signature and Date.

The electronic clinical record contained five scanned dialysis communication sheets dated 5/16/17, 10/1/16, 11/5/16, 12/13/16 and one that was undated.

The five dialysis communication sheets did not include any signatures of the nurse assessor.

The surveyor reviewed the progress notes for post dialysis assessment requirements for 5/16/17, 12/13/16, 11/5/16, and 10/1/16. No evidence of assessment of pre and post dialysis weight, skin assessments, or vital signs.

The surveyor reviewed the April 2017 through May 2017 dialysis communication forms that had not been scanned into the electronic clinical record.

4/4/17 Dialysis Communication Form had been completed; however, the electronic clinical record did not reveal vital signs, pre/post dialysis weights or a skin assessment had been completed.

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4/6/17 Dialysis Communication Form had not been completed by the dialysis center except for a pre-weight. The clinical record did not have an assessment of Resident #13's weight pre or post dialysis, vital signs or a skin assessment.

4/8/17 Dialysis Communication Form had not been completed by the dialysis center. The clinical record did not have an assessment of Resident #13's weight pre or post dialysis, vital signs or a skin assessment.

4/13/17 Dialysis Communication Form had not been completed by the dialysis center. The clinical record did not have an assessment of Resident #13's weight pre or post dialysis or a skin assessment.

4/15/17 The clinical record did not have an assessment of Resident #13's weight pre or post dialysis or a skin assessment.

4/18/17 Dialysis Communication Form had not been completed by the dialysis center. The clinical record did not have an assessment of Resident #13's weight pre or post dialysis, vital signs or a skin assessment.

4/20/17 The clinical record did not have an assessment of Resident #13's weight pre or post dialysis, vital signs or a skin assessment.

4/22/17 The clinical record did not have an assessment of Resident #13's weight pre or post dialysis, vital signs or a skin assessment.

4/25/17 The clinical record did not have an assessment of Resident #13's weight pre or post

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dialysis, vital signs or a skin assessment.

4/27/17 The clinical record did not have an assessment of Resident #13's weight pre or post dialysis, vital signs or a skin assessment.

4/29/17 The clinical record did not have an assessment of Resident #13's weight pre or post dialysis, vital signs or a skin assessment.

5/2/17 and 5/4/17 Dialysis Communication Forms had not been completed by the dialysis center. The clinical record did not have an assessment of Resident #13's weight pre or post dialysis, vital signs or a skin assessment.

5/6/17 The clinical record did not have a skin assessment upon return from dialysis.

5/9/17 Dialysis Communication Form had not been completed by the dialysis center. The clinical record did not have an assessment of Resident #13's weight pre or post dialysis, vital signs or a skin assessment.

5/11/17 The clinical record did not have a skin assessment upon return from dialysis.

5/13/17 Dialysis Communication Form had not been completed by the dialysis center. The clinical record did not have an assessment of Resident #13's skin.

5/18/17 Dialysis Communication Form had not been completed by the dialysis center. The clinical record did not have an assessment of Resident #13's weight pre or post dialysis, vital signs or a skin assessment.

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5/20/17 The clinical record did not have a vital signs assessment or a skin assessment upon return from dialysis.

The surveyor interviewed the unit manager registered nurse #3 on 5/25/17 at 10:00 a.m. R.N. #3 stated that nurses needed to assess the shunt for any bleeding, thrill, bruit upon return from dialysis as well as the weight and vital signs. R.N. #3 stated now she had a contact person at the dialysis center so communication of information between the dialysis center and the facility will be better.

The surveyor informed the administrative staff of these findings on 5/24/17 at 3:20 p.m.

The surveyor requested the facility policy on dialysis and the current dialysis contract for review on 5/25/17.

The SNF Outpatient Dialysis Services Agreement signed by both parties on 9/21/12 and 9/24/12 contained the following statement, "Both parties shall ensure that there is documented evidence of collaboration of care and communication between the Nursing facility and ESRD Dialysis Unit. Documentation shall include, but not be limited to, participation in care conferences, continual quality improvement program, annual review of infection control of policies and procedures, and the signatures of team members from both parties on a Short Term Care Plan and Long Term Care Plan. Team members shall include the physician, nurse, social worker and dietician from the ESRD Dialysis Unit and a representative from the Nursing facility. The ESRD Dialysis Unit shall keep the original STCP and LTCP in the medical record of ESRD Resident and the Nursing Facility

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shall maintain a copy."

The facility policy titled "Hemodialysis" was reviewed 5/25/17. The policy read in part "7. The Dialysis Communication Form will be initiated prior to sending patient for dialysis. A dialysis's center designated form may be used in place of MFA's Dialysis Communication Form."

No additional information was provided prior to the exit on 5/25/17.

5. The facility staff failed to coordinate care between the dialysis center and the facility for Resident #20.

The clinical record of Resident #20 was reviewed 5/24/17 and 5/25/17. Resident #20 was admitted to the facility 12/19/07 and readmitted 12/16/16 with diagnoses that included but not limited to kidney failure, end stage renal disease, depressive disorder, sleep apnea, symbolic dysfunction, bipolar disorder, hyperlipidemia, glaucoma, and hypertension.

Resident #20's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/13/16 assessed the resident with a cognitive summary score of 12 out of 15 and without signs or symptoms of delirium, psychosis or behaviors that affected others. Resident #20 required extensive assistance with ADL (activities of daily living) and was noted to be incontinent of bowel and bladder. Resident #20 was assessed to receive dialysis under special treatments, procedures and programs.

Resident #20's current comprehensive care plan revised 2/13/17 included the need for

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hemo-dialysis r/t (related to) renal failure. Goals: will have immediate intervention should any s/sx (signs or symptoms) of complications from dialysis occur. Interventions: Check and change dressing as ordered at access site, do not draw blood or take B/P (blood pressure) in right arm with graft, monitor, document, report prn (as needed) any s/sx infection to access site: redness, swelling, warmth, or drainage.

Resident #20's clinical record had physician orders for dialysis three times a week (Tuesday, Thursday, and Saturday).

The dialysis communication sheets used to share the flow of information between the facility and dialysis (three days a week) were reviewed from 1/1/17 through 5/24/17. The dialysis form had three sections to be completed. Section A. Pre-Dialysis (to be completed by Health and Rehab Center). Section B: Dialysis (to be completed by Dialysis Center). Section C: Post-Dialysis (to be completed by Health and Rehab Center). Upon return to the Health and Rehab Center, please document the following: Vital Signs, Assessment of Dialysis Site/AV Fistula (dressing, drainage, bruit, thrill, distal pulse), Pre and Post Dialysis Weights and Skin Assessment Signature and Date."

1/3/17 No post dialysis assessment in the clinical record. Dialysis communication form not signed/dated by facility staff.

1/5/17 Dialysis communication form not signed or dated by facility staff. The clinical record had no vital signs assessed, skin assessment or pre/post dialysis weights.

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F 309	Continued From page 28 1/7/17 Dialysis communication form not signed or dated by staff and no assessment of vital signs, skin or pre/post dialysis weights in clinical record. Date at the top of the dialysis communication form was 1/10/17 but the date at the bottom of the dialysis communication form was 1/14/17. There was no documentation when the resident was at the dialysis center. There were no assessments of vital signs, skin or pre/post dialysis weights in clinical record. The 1/19/17 progress note did not have vital signs assessed, pre-post dialysis weights, or skin assessed. The 1/21/17 progress note did not have vital signs assessed, pre-post dialysis weights, or skin assessed. The 1/24/17 progress note had no vital signs, pre-post dialysis weights, or skin assessed. The 1/28/17 progress note had no vital signs assessed or pre/post weights. The 2/4/17 progress note did not have vital signs or pre/post weights. There was not a dialysis communication form for 2/9/17 and 2/14/17. The 2/18/17 progress note did not have vital signs assessed or pre/post weights documented/assessed. The 2/21/17, 2/25/17, 3/2/17, and 3/7/17 dialysis communication forms were not signed by the facility staff or dated and the clinical record did	F 309		

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not contain an assessment of vital signs, pre/post weights or a skin assessment.

No dialysis communication form provided by the facility for 3/9/17. The 3/9/17 progress note documented resident had dialysis today.

The 3/11/17 dialysis communication form had not been completed by the dialysis center and there was not a signature or date by the facility staff. No assessment of vital signs or pre/post weights in the note of 3/11/17.

The 3/18/17 dialysis communication form did not have a pre-dialysis assessment or an assessment completed by the dialysis center. The 3/18/17 progress note did not have vital signs assessed, pre/post dialysis weights or a skin assessment.

The 3/23/17 progress note did not have vital signs assessed, pre-post weights or a skin assessment.

The 3/28/17 dialysis communication form had not been signed/dated by the facility staff. No assessment of vital signs, pre-post weights or skin in the 3/28/17 progress note.

The 4/1/17 progress note read that resident became hypotensive at dialysis and in-house MD (medical doctor) notified. The progress note did not have evidence that the vital signs had been reassessed upon arrival back at the facility, there were no pre-post weights documented and no skin assessment had been completed.

The progress note for 4/4/17 had no assessment of vital signs, pre-post weights or a skin

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assessment.

No 4/11/17 dialysis communication sheet provided by the facility. The 4/11/17 14:45 (2:45 p.m.) progress note did state resident returned from dialysis.

The 4/15/17 dialysis communication form was not completed by the dialysis center and the progress note for 4/15/17 did not reveal evidence that vital signs, pre-post weights, or a skin assessment had been completed.

The 4/18/17 dialysis communication form was not signed/dated by the facility upon Resident #20's return from dialysis. The progress note of 4/18/17 had no vital signs or pre/post weights.

Dialysis communication form undated provided to the surveyor.

The 5/16/17 dialysis communication form was not signed/dated by the facility staff upon the resident's return from dialysis. There was no progress note for 5/16/17.

The 5/20/17 dialysis communication form was not completed by the dialysis center and there was not a progress note for 5/20/17.

The surveyor informed the administrative staff of the concern with Resident #20's dialysis communication forms and assessments in the end of the day meeting on 5/25/17 at 10:45 a.m.

No further information was provided prior to the exit conference on 5/25/17.

6. The facility staff failed to follow physician

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orders for medication administration for Resident #24. Licensed practical nurse #1 administered the "as needed medication" (Albuterol Sulfate Inhalation Solution, 0.083%--2.5mg/3ml) instead of the scheduled medication Duo-Neb 0.5 -2.5 (3) mg/3ml (milligram/milliliter) (Ipratropium Bromide/Albuterol Sulfate) during a medication pass observation and pour on 5/23/17 beginning at 4:28 p.m.

The surveyor observed a medication pass and pour on 5/23/17 beginning at 4:28 p.m. with L.P.N. #1. After administering two oral medications (Senokot S and Prilosec), L.P.N. #1 returned to the medication cart and stated Resident #24 also received a "Duo-Neb". L.P.N. #1 removed one vial from the box labeled "Albuterol Sulfate Inhalation Solution, 0.083%* 2.5 mg/3ml" with orders that read "Albuterol Sulfate 25 2.5 mg/3 ml vial-neb M 3 ml inhale orally via nebulizer every 3 hours as needed for SOB/Congestion." L.P.N. #1 prepared Resident #24's nebulizer machine with the medication from the box and began the treatment at 4:45 p.m. and stated the treatment lasted fifteen minutes.

After the medication observation on 5/23/17 and 5/24/17, the surveyor reconciled Resident #24's medications using the most recent signed physician orders. Resident #24 had current orders for Albuterol Sulfate every 3 hours as needed for SOB/Congestion and for Duo-Nebs four times a day (9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m.). L.P.N. #1 administered the "as needed" inhalation treatment of Albuterol Sulfate instead of the scheduled inhalation treatment (Duo Neb). A review of the May 23, 2017 medication administration record revealed no documentation that the "as needed" medication

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F 309	Continued From page 32 Albuterol Sulfate had been administered. L.P.N. #1 documented that he had administered the Duo Neb at 5:00 p.m. The surveyor was unable to reach L.P.N. #1 for an interview on 5/25/17. The surveyor informed the administrative staff of the above medication error during the end of the day meeting on 5/24/17 at 3:20 p.m. Resident #24 was admitted to the facility 2/24/17 with diagnoses that included but not limited to acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, obstructive sleep apnea, post-traumatic stress disorder, hypertension, obesity, schizoaffective disorder, and chronic ischemic heart disease. Resident #24's significant change in assessment minimum data set (MDS) assessment assessed the resident with a cognitive summary score of 15 out of 15. No further information was provided prior to the exit conference on 5/25/17.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		7/3/17

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(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

(1) Assess the resident for risk of entrapment from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, facility staff failed to ensure freedom from accident hazards for 1 of 30 residents in the survey sample (Resident #30).

The findings included.

Resident #30 was admitted to the facility on 2/13/17 with diagnoses including zoster with complications, dementia without behavior ; hypertension, and benign prostatic hypertrophy. On the admission Minimum Data Set assessment with assessment reference date 2/20/17, the resident scored 5/15 on the Brief Interview for Mental Status. The resident was assessed as without symptoms of delirium, psychosis, or behaviors affecting self or others, including wandering.

During clinical record review on 5/24/17, the surveyor noted there was no mention of an

F323
1. Resident #30 no longer resides at the facility.
2. Current residents with wanderguard devices in use were reviewed to ensure in use per physician order, appropriate facility protocol for door alarms and accurate documentation in the event an incident of elopement occurs. Corrections will be made immediately as indicated.
3. Current facility staff and licensed staff were educated regarding following physician order for wanderguards, facility protocol for door alarms, and documentation in the event of an elopement incident. Leadership staff will round daily 5X weekly X6 weeks to ensure wanderguards are in use per physician order and door alarms are responded to per facility protocol. Any issues will be addressed immediately at the time of

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incident reported to the office of licensure and certification. The report stated that the resident exited the facility on 2/16/17 and returned with injuries. A followup report indicated that the resident was "transferred to a locked unit" and the employee involved "terminated 2/21".

The resident's clinical record contained no entries, other than medication administration entries, from 2/14/17 at 13:02 until 2/17/17 at 05:16. The clinical record did not document the resident's status for 48 hours prior to the elopement or physical status on his return to the facility.

The resident's Treatment Administration Record for 2/1/17-2/28/07 documented and order dated 2/16/17 at 20:07 "May apply wanderguard, take resident to door and check q shift every shift" This order was documented as completed with a check mark and staff initials each shift from night shift on 2/16/17 through day shift on 2/22/17 except for except for evening shift on 2/18/17 and night shift on 2/20/27. No explanation was given for the omissions on those dates. No documentation was available to explain the actions which led to the placement of the wanderguard. No nursing or physician notes documented any behaviors prior to 2/17/17.

The clinical record documented X-ray results from Dynamic Mobile Imaging on 2/17/17 for "facial bones, less than 3 views","right hand, 3+views", and "left hand, 3+views". The clinical record did not document symptoms for which the three diagnostic tests were ordered.

The clinical record contained no physician note after admission. A discharge planning note

identification.
4. Process will be reviewed in QA committee for two quarters.

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documented informing the family that the resident required a memory care unit. There is no record of a physician level assessment concerning the requirement for a transfer to a higher level of care.

The surveyor discussed concerns about the cause of the elopement, the lack of documentation, and safety of other residents who might wander with the administrator and director of nursing on 5/24/17. The administrator reported that on the 16th (of February 2017), the patient "started moving around" and the wanderguard was placed. At 6:21 PM, the patient was not located in the building. At 6:21, the facility received a call that the resident had been spotted on Hemlock Dr. The administrator drove around the area and found the resident and returned him to the facility at 6:52 PM. The administrator and director of nursing conducted staff interviews. A CNA reported walking the resident to his room on unit 4 and returning to unit 1 and silencing the alarm for the wanderguard. The CNA was later terminated for failing to check that the resident was in his room before silencing the alarm.

The surveyor reported to the administrator and director of nursing concern that the wandering, placement of the wanderguard, elopement and later determination, reported in the facility reported event followup report, of the need for 15 minute checks did not appear in the clinical record. Physical assessment of the resident's status was documented as occurring on 2/17/17 at 8:22 AM, more than 12 hours after the resident's return to the facility with apparent injuries to the face and hands. The surveyor was also concerned that staff did not document checking the functionality of the wanderguard on

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F 323	Continued From page 36 2 separate shifts after the elopement. No nursing progress notes were documented for those 2 shifts.	F 323		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 441		7/3/17

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F 441	Continued From page 37 (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to wash hands between residents during a medication pass and pour observation that affected 2 of 31 residents (Resident #3 and Resident #24).	F 441	F441 1. Residents #3 and #24 are currently receiving medications during medication pass according to appropriate infection control practices specific to hand washing. 2. Current licensed nurses will be	

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The findings included:

A medication pass observation was conducted on 5/23/17 starting at 4:28 p.m. LPN #1 was observed setting up and administering medications to Resident #3 that included Vitamin C 500 mg, Culturelle, Lopressor 25 mg (3 tablets) and ProStat 30 cc. After L.P.N. #1 had administered all of the resident's medications, L.P.N. #1 immediately began setting up Resident #24's medications and was observed administering them. LPN #1 did not wash his hands after completion of the medication pass to Resident #3 and before preparing Resident #24's medications during the medication pass observation.

The surveyor informed the director of nursing and the corporate registered nurse of the surveyor's observation during the medication pass on 5/24/17 at 10:10 a.m. and asked both their expectations regarding handwashing. The DON stated she would expect the nurse to use hand sanitizer or wash hands between resident contacts.

The surveyor requested the facility policy on handwashing from the infection control nurse #1 on 5/24/17 at 10:15 a.m.

The facility policy titled "Handwashing Requirements" included "PROCEDURE: A. Hand Hygiene 1. The following is a list of some situations that require hand hygiene: b. When hands are visibly soiled (hand washing with soap and water); before and after direct patient contact (for which hand hygiene is indicated by acceptable professional standards). Wash hands before and after resident contact".

observed by nursing leadership staff during a medication pass administration to ensure hand washing practices are being followed. Any issues will be immediately corrected at the time of observation.
3. Licensed nursing staff will be educated regarding infection control procedures specific to hand washing during medication pass. Medication pass observations will be performed 2X weekly X 3 weeks then weekly X 3 weeks by nursing leadership. Any issues will be corrected immediately at the time of identification.
4. Process will be reviewed in QA committee for two quarters.

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F 441	Continued From page 39 The surveyor informed the administrative staff of the above concern during an end of the day meeting on 5/24/17 at 3:20 p.m. and again on 5/25/17 at 10:45 a.m. No further information was provided prior to the exit conference on 5/25/17.	F 441		
F 502 SS=D	483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) 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, the facility staff failed to obtain physician ordered laboratory tests for 1 of 31 residents (Resident #13). The findings included: The facility staff failed to obtain a PT/INR ordered to be done 3/30/17 for Resident #13. The clinical record of Resident #13 was reviewed 5/23/17 and 5/24/17. Resident #13 was admitted to the facility 12/6/13 with diagnoses that included but not limited to end stage renal disease, hypotension, dementia without behavioral disturbances, type 2 diabetes mellitus, dysphagia, and hyperlipidemia. Resident #13's annual minimum data set (MDS) assessment with an assessment reference date	F 502	F502 1. Resident #13 s MD was notified of missed PT/INR laboratory test. No new orders recveived. 2. Current residents with active laboratory test orders for PT/INR were reviewed to ensure complete per MD order. Corrections were made immediately as applicable. 3. Licensed nursing staff were educated regarding laboratory process to include accurate order transcription. Nursing leadership will review order listing report daily 5X weekly X6 weeks to ensure PT/INR test orders have transcribed accurately for completion. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters.	7/3/17

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F 502	Continued From page 40 (ARD) of 3/28/17 assessed the resident with a cognitive summary score of 11. The current physician's orders included the following: "PT/INR on 3/30/17." The surveyor reviewed the PT/INR Flowsheet kept at the nurse's station. The flowsheet did not have the results of the 3/30/17 PT/INR order. The surveyor informed the administrative staff of the physician order for the PT/INR for 3/30/17 and unable to locate the results in the end of the day meeting on 5/24/17 at 3:20 p.m. No further information was provided prior to the exit conference on 5/25/17.	F 502		
F 504 SS=D	483.50(a)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN (a) Laboratory Services (2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a physician order before obtaining PT/INRs for 1 of 31 residents (Resident #13). The findings included:	F 504	F504 1. The physician was notified of PT/INR done on 4/5/17, 5/5/17, and 5/11/17 for Resident #13. 2. Nursing leadership will review current residents with active PT/INR lab test orders to ensure tests have been	7/3/17

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F 504	Continued From page 41 The facility staff obtained PT/INRs on 4/5/17, 5/5/17 and 5/11/17 without a physician order for Resident #13. The clinical record of Resident #13 was reviewed 5/23/17 and 5/24/17. Resident #13 was admitted to the facility 12/6/13 with diagnoses that included but not limited to end stage renal disease, hypotension, dementia without behavioral disturbances, type 2 diabetes mellitus, dysphagia, and hyperlipidemia. Resident #13's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/28/17 assessed the resident with a cognitive summary score of 11. The surveyor reviewed the PT/INR Flowsheet kept at the nurse's station for Resident #13. The flowsheet had the results of PT/INRs obtained 4/5/17, 5/5/17, and 5/11/17. The surveyor was unable to locate a physician order for the three laboratory tests. The surveyor informed the administrative staff of the PT/INRs obtained 4/5/17, 5/5/17, and 5/11/17 without a physician order in the end of the day meeting on 5/24/17 at 3:20 p.m. No further information was provided prior to the exit conference on 5/25/17.	F 504	completed as indicated per physician order. Any issues will be addressed immediately at the time of identification. 3. Current licensed nursing staff will be educated regarding lab test orders to include order accuracy and tracking. Unit managers or designee will review lab tracking log daily 5 X weekly X 6 weeks to ensure lab tests have been completed per MD order. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters.	
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must	F 514		7/3/17

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maintain medical records on each resident that are-

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 5 of 31 residents, Residents #31, #4, #20, #17, and #30.

The findings included.

1. For Resident #31, the facility nursing failed to

F514
1. Resident #31 no longer resides in the facility. Resident #4 no longer receives Clindamycin and MD was made aware of omission with no new orders. Resident #20 s record has been corrected to remove another patient. s dialysis form. Resident #17 s record was corrected to

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document on several different dates and times on the Residents eMARs (electronic medication administration records) for February and March 2017 that the Residents medications had been administered.

The clinical record review revealed that Resident #31 had been admitted to the facility 07/23/14. Diagnoses included, but were not limited to, epilepsy, intellectual disabilities, gastroesophageal reflux disease, anxiety, neuropathy, and hemiplegia.

The Resident had been discharged on 04/07/17.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/16/16 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.

A review of the Residents eMARs for February and March 2017 indicated that the facility nursing staff had not documented that the Residents medications had been administered on the following dates and times.

For February 2017-
February 1 and 13 at 9:00 a.m. and 11:00 a.m. all the administration blocks were left blank.
February 19 and 23 at 8:00 p.m. and 9:00 p.m. all the administration blocks were left blank.

For March 2017-
March 4 and 5 at 9:00 a.m. and 11:00 a.m. all the administration blocks were left blank.
March 5, 13, 18, and 30 at 8:00 p.m. and 9:00 p.m. all the administration blocks were left blank.

remove another patient s psychological evaluation form. Resident #30 no longer resides in the facility.
2. Current residents MARs for June 2017 were reviewed to ensure accuracy of medication administration documentation. Current residents receiving dialysis and psychological evaluations were reviewed to ensure communication forms and consultation forms are scanned into correct record. Current residents with wanderguard devices in use were reviewed to ensure behaviors are documented as applicable. Corrections were made immediately as applicable.
3. Licensed nursing staff were educated regarding accuracy of medication administration, scanning documents accurately into electronic record, and documentation of behaviors associated with wanderguard use as applicable. Nursing leadership will review dialysis communication forms 2X weekly X6 weeks to ensure accuracy of documentation. Medical records staff will scan documents weekly only after validating review by nursing leadership X 6 weeks. Nursing leadership will review shift reports daily 5 X week X 6 weeks to identify need for behavior documentation associated with wandering. Any issues will be addressed immediately at the time of identification.
4. Process will be reviewed in QA committee for two quarters.

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On 05/24/17 at approximately 5:20 p.m. the surveyor interviewed LPN (licensed practical nurse) #1. LPN #1 reviewed the eMARs with the surveyor and then stated she knew she had administered the medications and that the Resident was very compliant with taking medications for her.

On 05/24/17 at approximately 5:30 p.m. the surveyor interviewed LPN #2, LPN #2 also verbalized to the surveyor that she was sure she had administered the Residents medications, LPN #2 stated she guess she had backed out of the system and it hadn't saved her work.

On 05/24/17 the DON (director of nursing) shared with the surveyor copies of write up reports for both nurses dated 03/22/17 for failure to sign off for administration of medications.

The administrative staff were notified of the above issues during a meeting with the survey team on 05/24/17 at 3:20 p.m. and again on 05/25/17 at 10:45 a.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. The facility staff failed to document when medications were administered for Resident #4.

The facility staff failed to document when Clindamycin 150 mg (milligram) capsule was administered on 5/3/17 at 0600 to Resident #4.

The clinical record of Resident #4 was reviewed 5/23/17 and 5/24/17. Resident #4 was admitted to the facility 9/25/15 and readmitted 1/1/17 with

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diagnoses that included but not limited to gastrointestinal hemorrhage, colon cancer with colostomy, depressive disorder, atrial fibrillation, gangrene, anxiety, malnutrition, chronic diastolic congestive heart failure, peripheral vascular disease, hypertension, and traumatic amputation of right lesser toe.

Resident #4's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/6/17 assessed the resident with a cognitive summary score of 9 out of 15 and without signs or symptoms of delirium, psychosis or behaviors that affected others.

A verbal order dated 5/1/17 23:08 (11:08 p.m.) for Resident #4 read "Clindamycin HCL Capsule 150 mg Give 150 mg by mouth every 6 hours for infection for 7 days."

The May 2017 electronic medication administration record (eMAR) was reviewed. The entry for 5/3/17 at 0600 was blank. There were no progress notes for 5/3/17 in the clinical record pertaining to why the medication had not been administered.

The surveyor informed the corporate registered nurse of the above concern on 5/24/17 at 10:15 a.m. and stated she saw where the medication had been missed.

The surveyor informed the administrative staff of the above concern in the end of the day meeting on 5/24/17 at 3:20 p.m.

On 5/25/17 at 8:00 a.m., the director of nursing provided the surveyor with a handwritten statement dated 5/22/17 that read "I, registered

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nurse #5, was the 11-7 nurse on unit one on 5/3/17. I administered Clindamycin to Resident #4 twice that shift-once at approximately midnight and again at approximately 6am."

No further information was provided prior to the exit conference on 5/25/17.

3. The facility staff failed to ensure Resident #20's clinical record was accurate. Resident #20's scanned clinical record contained an undated dialysis communication form of another resident.

The clinical record of Resident #20 was reviewed 5/24/17 and 5/25/17. Resident #20 was admitted to the facility 12/19/07 and readmitted 12/16/16 with diagnoses that included but not limited to kidney failure, end stage renal disease, depressive disorder, sleep apnea, symbolic dysfunction, bipolar disorder, hyperlipidemia, glaucoma, and hypertension.

Resident #20's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/13/16 assessed the resident with a cognitive summary score of 12 out of 15 and without signs or symptoms of delirium, psychosis or behaviors that affected others. Resident #20 required extensive assistance with ADL (activities of daily living) and was noted to be incontinent of bowel and bladder. Resident #20 was assessed to receive dialysis under special treatments, procedures and programs.

During the review of Resident #20's scanned dialysis communication forms, the surveyor noted the first one scanned was a dialysis communication form for another resident. The

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date when scanned was 8/13/16; however, there was not a date on the dialysis form.

The surveyor requested a copy to be printed from the corporate registered nurse on 5/25/17 at 10:30 a.m. After receiving the document, the corporate registered nurse stated the medical records staff had not done the scanning but the nurses on the floor had scanned that particular document.

The surveyor informed the administrative staff of the error in the scanning of the dialysis communication form in the clinical record of Resident #20 in the end of the day meeting on 5/25/17 at 10:45 a.m.

No further information was provided prior to the exit conference on 5/25/17.

4. The facility failed to ensure a complete and accurate clinical record for Resident #17.

Resident #17 was readmitted to the facility on 2/14/17 with the following diagnoses of, but not limited to high blood pressure, ulcerative colitis, arthritis, dementia, seizure disorder, manic depression, GERD and Schizophrenia. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/9/17 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 9 out of a possible score of 15. The resident requires extensive assistance of 1 staff member for dressing, eating and personal hygiene.

The surveyor performed a clinical record review on 5/24/17. The surveyor noted another resident's psychiatric evaluation dated for 3/2/17 in Resident #17's clinical record.

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The administrative team was notified of the above documented findings on 5/24/17 at 3:25 pm in the conference room by the surveyor.

No further information was provided to the surveyor prior to the exit conference on 3/25/17.
5. For Resident #30, facility staff failed to document behaviors leading to placement of a wanderguard, elopement of the resident with injury tot the resident, and subsequent monitoring of the resident's location.

Resident #30 was admitted to the facility on 2/13/17 with diagnoses including zoster with complications, dementia without behavior ; hypertension, and benign prostatic hypertrophy. On the admission Minimum Data Set assessment with assessment reference date 2/20/17, the resident scored 5/15 on the Brief Interview for Mental Status. The resident was assessed as without symptoms of delirium, psychosis, or behaviors affecting self or others, including wandering.

During clinical record review on 5/24/17, the surveyor noted there was no mention of an incident reported to the office of licensure and certification. The report stated that the resident exited the facility on 2/16/17 and returned with injuries. A followup report indicated that the resident was "transferred to a locked unit" and the employee involved "terminated 2/21".

The resident's clinical record contained no entries, other than medication administration entries, from 2/14/17 at 13:02 until 2/17/17 at 05:16. The clinical record did not document the resident's status for 48 hours prior to the

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elopement or physical status on his return to the facility.

The resident's Treatment Administration Record for 2/1/17-2/28/07 documented and order dated 2/16/17 at 20:07 "May apply wanderguard, take resident to door and check q shift every shift" This order was documented as completed with a check mark and staff initials each shift from night shift on 2/16/17 through day shift on 2/22/17 except for except for evening shift on 2/18/17 and night shift on 2/20/27. No explanation was given for the omissions on those dates. No documentation was available to explain the actions which led to the placement of the wanderguard. No nursing or physician notes documented any behaviors prior to 2/17/17.

The clinical record documented X-ray results from Dynamic Mobile Imaging on 2/17/17 for "facial bones, less than 3 views","right hand, 3+views", and "left hand, 3+views". The clinical record did not document symptoms for which the three diagnostic tests were ordered.

The clinical record contained no physician note after admission. A discharge planning note documented informing the family that the resident required a memory care unit. There is no record of a physician level assessment concerning the requirement for a transfer to a higher level of care.

The surveyor discussed concerns about the cause of the elopement, the lack of documentation, and safety of other residents who might wander with the administrator and director of nursing on 5/24/17. The administrator reported that on the 16th (of February 2017), the patient

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"started moving around" and the wanderguard was placed. At 6:21 PM, the patient was not located in the building. At 6:21, the facility received a call that the resident had been spotted on Hemlock Dr. The administrator drove around the area and found the resident and returned him to the facility at 6:52 PM. The administrator and director of nursing conducted staff interviews. A CNA reported walking the resident to his room on unit 4 and returning to unit 1 and silencing the alarm for the wanderguard. The CNA was later terminated for failing to check that the resident was in his room before silencing the alarm.

The surveyor reported to the administrator and director of nursing concern that the wandering, placement of the wanderguard, elopement and later determination, reported in the facility reported event followup report, of the need for 15 minute checks did not appear in the clinical record. Physical assessment of the resident's status was documented as occurring on 2/17/17 at 8:22 AM, more than 12 hours after the resident's return to the facility with apparent injuries to the face and hands. The surveyor was also concerned that staff did not document checking the functionality of the wanderguard on 2 separate shifts after the elopement. No nursing progress notes were documented for those 2 shifts.