STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495344	A. BUILDING ______ B. WING ______	C 06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGS DAUGHTERS COMMUNITY HEALTH & REHAB	1410 NORTH AUGUSTA STREET STAUNTON, VA 24401

(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
E 000	Initial Comments An unannounced Medicare/Medicaid standard survey was conducted 6/26/18 through 6/28/18. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 06/26/2018 through 06/28/2018. The facility was not in compliance with 42 CFR Part 483, the Federal Long Term Care requirements. One complaint was investigated. Corrections are required for compliance with the following Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 117 certified bed facility was 107 at the time of the survey. The survey sample consisted of 22 current Resident reviews and three (3) closed record reviews.	F 000		
F 550 SS=B	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		8/1/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/13/2018

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

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, resident interview, and staff interview, the facility staff failed to maintain the dignity on one of 25 residents in the survey sample (Resident # 69). The facility staff posted signs on the wall at the head of Resident # 69's bed, and on the wall adjacent to the resident's bed, regarding the handling of the resident's laundry, and eating methods.	F 550	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this plan of correction. In addition, the following plan constitutes the center's	

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F 550	Continued From page 2 The findings were: Resident # 69 in the survey sample, was admitted to the facility on 3/20/17 with diagnoses that included encephalopathy, depression, hypertension, hyperlipidemia, hemiplegia, seizure disorder, anxiety disorder, chronic obstructive pulmonary disease, and dysphagia. According to the most recent Minimum Data Set, a Quarterly with an Assessment Reference Date of 5/24/18, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 10 out of 15. During the orientation tour at 11:20 a.m. on 6/26/18, two signs posted on the wall behind the head of the resident's bed were visible from the doorway of the resident's room. The signs, written in large, block letters, read "Family to do laundry." After obtaining permission from the resident to enter her room, the surveyor observed three more signs on the wall adjacent to her bed. One of the signs, written in large, block letters, was the same as the two signs on the wall behind the resident's bed, and also read "Family to do laundry." The other two signs had to do with the resident's eating. Both were written in large, block letters, with one reading "Don't forget to tuck your chin," and the other reading "Safe swallowing strategies: Small bites, Chew extra long, Swallow hard."	F 550	allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated. F550 1. For Resident #69, posted signs without a physician's orders or signed consent from the resident and/or the responsible party have been removed from the room and disposed of. 2. A review has been conducted by Director of Clinical Services/designee to ensure that posted signs in the facility without a physician's orders or signed consent from the resident and/or the responsible party been removed. 3. Facility Staff has received re-education by Director of Clinical Services/designee regarding resident rights/dignity related to signage posted revealing resident information. 4. DCS/Designee to conduct random weekly Quality Improvement Monitoring of no less than 5 resident room for signage revealing resident information x 2 months then monthly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 550	Continued From page 3 At 8:30 a.m. on 6/27/18, the surveyor returned to the resident's room for an interview. The resident had just finished breakfast. Her breakfast tray was still on her overbed table, and it appeared she had eaten approximately 80% of her breakfast. Asked about the eating signs, and specifically if she pays attention to them, the resident laughed, shook her head "No," and said, "I know how to eat. She (speech therapist) seems to think it's a problem." At 11:30 a.m. on 6/27/18, the Speech Therapist (ST) was interviewed about the eating signs "She has some swallowing problems. I thought the swallowing strategies would be helpful for her," the ST said. The findings were discussed with the Administrator and the Director of Nursing during a meeting with the survey team at 2:00 p.m. on 6/28/18.	F 550		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(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 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	F 656		8/1/18

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F 656	Continued From page 4 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 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for two of 25 residents in the survey sample. 1. Resident #17 had no individualized care plan developed regarding behaviors. 2. Resident #98 had no individualized care plan developed regarding care for chronic scalp	F 656	F656 1. Resident #17 care plan has been revised; comprehensive individualized behavior interventions implemented. Resident #98 care plan has been revised; comprehensive individualized scalp wound interventions implemented. 2. Director of Clinical Services/Designee has conducted a Quality Review of	

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F 656 Continued From page 5
wounds.

The findings include:

1. Resident #17 was admitted to the facility on 3/17/18 with diagnoses that included anxiety, dementia with behavioral disturbance, respiratory failure, cellulitis and congestive heart failure.

The minimum data set (MDS) date 3/17/18 assessed Resident #17 with severely impaired cognitive skills.

Resident #17's clinical record documented the resident was at times resistant to care and refused meals. A nursing note dated 6/18/18 documented, "She [Resident #17] refused both breakfast and lunch trays..." A note dated 6/21/18 stated, "Res. [Resident] became combative while receiving incontinent care, kicking her foot board and smacking her bed rails with her fists and palm of her hands, tried several times to redirect Res behavior but she continued to be non-compliant..."

Resident #17 had no plan of care developed with individualized interventions regarding behaviors. Resident #17's plan of care (revised 6/20/18) listed the resident had inappropriate behaviors that included care rejection and physical/verbal behaviors directed toward others. The only intervention documented to minimize behaviors was, "Anticipate and address resident needs."

On 6/28/18 at 9:07 a.m., the licensed practical nurse (LPN #1) caring for Resident #17 was interviewed about a behavior care plan. LPN #1 stated the resident demonstrated behaviors mostly in the evening and at night. LPN #1 stated

F 656

residents with behaviors care plans for implementation of individualized interventions. Director of Clinical Services/Designee has conducted a Quality Review of residents with scalp wounds care plans for implementation of individualized interventions. Follow up based on findings.

3. Regional MDS Coordinator has provided re-education to facility MDS Department regarding implementation of comprehensive individualized care plans. Director of Clinical Services/Designee has provided Licensed Nurses re-education regarding implementation of comprehensive individualized care plans.

4. Director of Clinical Services/Designee to conduct Quality Improvement Monitoring of residents with behaviors and scalp wounds for implementation of comprehensive individualized care plans weekly x 6 weeks, then monthly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.

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if the resident was resistant to care, she re-approached her later. LPN #1 stated the resident liked familiar faces and was not receptive to new caregivers. LPN #1 stated she thought the unit managers were responsible for updating the care plans.

On 6/28/18 at 9:10 a.m., the registered nurse unit manager (RN #1) was interviewed about Resident #17's care plan for behaviors. RN #1 stated the care plan was reviewed at the time of the care plan meeting and that problems/interventions were added as needed by nursing. RN #1 stated interventions implemented for Resident #17's behaviors included re-direction, re-approaching at a later time and making sure the resident's oxygen was administered as ordered. RN #1 stated she did not know why their interventions were not on the care plan.

On 6/28/18 at 9:55 a.m., the MDS coordinator (RN #2) was interviewed. RN #2 stated she was not sure why interventions were not listed regarding Resident #17's behaviors. RN #2 stated the social worker was responsible for developing the care plan concerning behaviors.

These findings were reviewed with the administrator and director of nursing during a meeting on 6/28/18 at 1:30 p.m.

2. Resident #98 was admitted to the facility on 5/13/18 with diagnoses that included high blood pressure, angiosarcoma of scalp, anxiety, depression and hyperlipidemia.

The minimum data set (MDS) dated 6/10/18 assessed Resident #98 as cognitively intact.

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F 656	Continued From page 7 On 6/27/18 at 1:46 p.m., Resident #98 was observed with two irregular shaped lesions on the top of her head. The areas were approximately 2 inches in length and up to 1 inch wide. The lesions were red and partially covered with scab with several areas noted with active bleeding. Residen t#98 was scratching the edges of the wounds and stated the areas itched frequently. Resident #98 stated the lesions were from the removal of a cancer and the areas had been there over a year. Resident #98 stated the areas were currently treated with hydrocortisone cream. Resident #98's plan of care (revised 6/14/18) included no problems, goals and/or interventions regarding care/treatment of the scalp lesions. On 6/28/18 at 8:41 a.m., the registered nurse unit manager (RN #1) was interviewed about a plan of care for the scalp lesions. RN #1 stated the status of the resident's scalp wounds (bleeding, itching) had not been brought to her attention. RN #1 stated the unit managers updated care plans as needed. RN #1 stated the resident was new to her unit and she did not do the initial care plan. On 6/28/18 at 9:01 a.m., the licensed practical nurse (LPN #1) caring for Resident #98 was interviewed about the scalp lesions. LPN #1 stated the scalp lesions usually looked like a "dry scab." LPN #1 stated the unit managers and MDS created and updated care plans. On 6/28/18 at 10:00 a.m., the MDS coordinator (RN #2) was interviewed about a plan of care regarding Resident #98's scalp wounds. RN #2 stated MDS nurses and/or the unit manager were	F 656		

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F 656	Continued From page 8 responsible for developing care plans. RN #2 stated the last care plan meeting for Resident #98 was held on 5/20/18. These findings were reviewed with the administrator and director of nursing during a meeting on 6/28/18 at 1:30 p.m.	F 656		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of care for one of 25 residents in the survey sample. Nurses failed to document multiple doses of the controlled medications Dilaudid and Xanax when administered to Resident #38. The findings include: Resident #38 was admitted to the facility on 5/1/15 with diagnoses that included anemia, morbid obesity, hypothyroidism, gastroesophageal reflux disease, high blood pressure, anxiety and chronic pain.	F 684	F684 1. Resident #38 pain assessment has been updated. Resident #38's Medical Record reflects Dilaudid and Xanax administration documented per standard of practice. 2. Director of Clinical Services/Designee has conducted a Quality Review of Medication Administration Records for residents receiving controlled medications for documentation reflective of administration per standard of practice... Follow up based on findings. 3. Director of Nursing/Designee provided Licensed Nurses re-education regarding	8/1/18

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F 684	Continued From page 9 The minimum data set (MDS) dated 5/5/18 assessed Resident #38 as cognitively intact. On 6/26/18 at 3:30 p.m., Resident #38 was interviewed about quality of life in the facility. Resident #38 stated that she requested and was administered the medications Dilaudid and Xanax multiple times most days for management of her pain and anxiety. Resident #38's clinical record documented a physician's order dated 4/17/18 for Dilaudid 2 mg (milligrams) to be administered every 4 hours as needed for pain. The record also documented a physician's order dated 6/26/18 for Xanax .25 mg to be administered every 4 hours as needed for anxiety. Resident #38's medication administration record (MAR) for June 2018 was reviewed and compared to the narcotic count sheets for the Dilaudid and Xanax. Fifty (50) doses of Dilaudid 2 mg were signed out on the controlled medication utilization record (count sheet) from 6/12/18 through 6/26/18. Only 26 of the 50 doses were marked on the MAR as administered to Resident #38. Twenty-four doses of Dilaudid signed out on the count sheet were not recorded as given to the resident. The controlled medication utilization record for Resident #38's Xanax .25 mg listed 31 doses signed out from 6/18/18 through 6/27/18. Nurses documented only 16 out of these 31 doses of Xanax .25 mg as administered to Resident #38, leaving fifteen doses of Xanax signed out but not recorded as given to the resident. On 6/27/18 at 9:33 a.m., the licensed practical	F 684	standards of practice for documentation of controlled medications upon administration. 4. DCS/Designee to conduct Quality Improvement Monitoring of residents receiving controlled medications Administration Records for documentation per standard of practice/regulation. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 684	Continued From page 10	F 684		

nurse (LPN #1) routinely administering medications to Resident #38 was interviewed about the Dilaudid and Xanax signed out of the narcotic box but not listed as administered. LPN #1 stated Resident #38 requested the as needed Dilaudid and Xanax "pretty regular" on most days. LPN #1 reviewed with utilization count sheets and the MAR and stated she did not know why the Dilaudid and Xanax were signed out but not marked as given. LPN #1 stated medications were supposed to be recorded on the MAR at the time administered. LPN #1 stated she always documented controlled medications from the locked box on the MAR.

On 6/27/18 at 9:35 a.m., the registered nurse unit manager (RN #1) was interviewed about Resident #38's Dilaudid and Xanax not marked on the MAR as given. RN #1 stated, "Looks like they [nurses] signed it [medication] out the narc [narcotic] box but did not sign off the MAR." RN #1 stated she had recently identified problems with some nurses not signing the MAR when medications were given. RN #1 stated nurses were supposed to sign off the MAR at the time medications were administered.

On 6/28/18 at 8:34 a.m., RN #1 was interviewed again about lack of an administration record for multiple doses of Resident #38's Dilaudid and Xanax. RN #1 stated nurses were taught to document all medications given. RN #1 stated if a nurse signed a medication out of the narcotic box, they were expected to administer the medication and sign off the MAR. RN #1 stated she had reviewed the records and multiple nurses failed to mark doses as given on the MAR. RN #1 stated both nurses on the night shift (11:00 p.m. to 7:00 a.m.) were not marking the Dilaudid

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and Xanax as given even though they were signed out on the count sheets.

On 6/28/18 at 11:25 a.m., the DON was interviewed about nurses not signing medications as administered. The DON stated, "We teach them [nurses] to write on the MAR." The DON stated the facility did not have a policy specifically about writing narcotics on the administration record. When asked how they were sure the controlled medications were administered to the resident, the DON stated pain assessments for Resident #38 indicated effective pain management.

On 6/28/18 at 12:40 p.m., the facility's consultant pharmacist was interviewed by telephone about Resident #38's Dilaudid and Xanax not on the MAR. The pharmacist stated it was required for all medications given to be documented on the MAR, especially controlled medications. The pharmacist stated he "spot checks" narcotics with the MARs during his monthly reviews but he was not aware of any issues with nurses not documenting controlled medications. The pharmacist stated accountability was required for all medications given including all controlled medications.

The facility's policy titled Medications - Oral Administration Of (revised 9/22/17) included in steps for medication administration, "...Chart of Medication Administration Record (MAR) according immediately following when medication is given and before proceeding to the next resident..." (sic)

The facility's policy title of Acceptance of Controlled Drug (8/24/17) stated it was policy to

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGS DAUGHTERS COMMUNITY HEALTH & REHAB	1410 NORTH AUGUSTA STREET STAUNTON, VA 24401

(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 684	Continued From page 12 "ensure controlled drugs are properly accounted for in accordance with Federal Regulations." This policy stated, "Controlled dugs will be delivered to the facility by the pharmacy in a sealed, tamper proof container...Two nurses will open the controlled drug container and reconcile the controlled drugs including but not limited to: correct medication, dosage, amounts...Controlled medications are then place in medication carts by nurses...If discrepancies are found during reconciliation notify the pharmacy and the Director or Nursing. Discrepancies may include but are not limited to: missing controlled drugs, incorrect quantities, damaged containers or seals..." (sic) The Lippincott Manual of Nursing Practice 10th edition on page 16 states regarding professional standards of care, "Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to...follow physician orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record, administer medications as ordered..." (1) The Nursing 2017 Drug Handbook on page 1603 states concerning patient safety during drug therapy, "...Applying the nurse process (assessment, nursing diagnosis, planning, intervention, and evaluation) during drug therapy enables the nurse to systematically identify the drug therapy needs of each patient, thereby reducing the number of adverse events and providing safe patient care..." Nursing steps listed for safe drug therapy included, "... Document medication administration..." (2)	F 684		

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F 684	Continued From page 13 The Nursing 2017 Drug Handbook on page 734 described Dilaudid (hydromorphone) as an opioid analgesic and a schedule II controlled substance used to the treatment of moderate to severe pain. Page 736 of this reference states Dilaudid has a Black Box Warning and documents, "Hydromorphone is an opioid agonist with an abuse liability similar to other opioid agonists, legal and illicit...Routinely monitor all patients for signs and symptoms of misuse, abuse, and addiction during treatment." Page 1588 of this reference states schedule II drugs have, "High abuse potential with severe dependence liability..." (2) The Nursing 2017 Drug Handbook on page 109 describes Xanax as an anxiolytic used for the treatment of anxiety and panic disorders. Page 1588 of this reference includes Xanax as a controlled schedule IV medication with less abuse potential than schedule II or III drugs and limited dependence liability. (2) (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014. (2) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.	F 684		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755		8/1/18

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F 755	Continued From page 14 §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure accurate accountability of controlled medications for one of 25 residents in the survey sample. Multiple doses of the controlled medications Dilaudid and Xanax were signed out of the narcotic lock box for Resident #38 but were not marked as administered to the resident.	F 755	F755 1. Resident #38 pain assessment has been updated. Resident #38's Medical Record reflects Dilaudid and Xanax administration documented per standard of practice. 2. Director of Clinical Services/Designee has conducted a Quality Review of Medication Administration Records for	

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The findings include:

Resident #38 was admitted to the facility on 5/1/15 with diagnoses that included anemia, morbid obesity, hypothyroidism, gastroesophageal reflux disease, high blood pressure, anxiety and chronic pain.

The minimum data set (MDS) dated 5/5/18 assessed Resident #38 as cognitively intact.

On 6/26/18 at 3:30 p.m., Resident #38 was interviewed about quality of life in the facility. Resident #38 stated that she requested and was administered the medications Dilaudid and Xanax multiple times most days for management of her pain and anxiety.

Resident #38's clinical record documented a physician's order dated 4/17/18 for Dilaudid 2 mg (milligrams) to be administered every 4 hours as needed for pain. The record also documented a physician's order dated 6/26/18 for Xanax .25 mg to be administered every 4 hours as needed for anxiety.

Resident #38's medication administration record (MAR) for June 2018 was reviewed and compared to the narcotic count sheets for the Dilaudid and Xanax. Fifty (50) doses of Dilaudid 2 mg were signed out on the controlled medication utilization record (count sheet) from 6/12/18 through 6/26/18. Only 26 of the 50 doses were marked on the MAR as administered to Resident #38. Twenty-four doses of Dilaudid signed out on the count sheet were not recorded as given to the resident. The controlled medication utilization record for Resident #38's

F 755

residents receiving controlled medications for documentation reflective of administration per standard of practice... Follow up based on findings.

3. Director of Nursing/Designee provided Licensed Nurses re-education regarding standards of practice for documentation of controlled medications upon administration.

4. DCS/Designee to conduct Quality Improvement Monitoring of residents receiving controlled medications Administration Records for documentation per standard of practice/regulation. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.

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F 755	Continued From page 16 Xanax .25 mg listed 31 doses signed out from 6/18/18 through 6/27/18. Nurses documented only 16 out of these 31 doses of Xanax .25 mg as administered to Resident #38, leaving fifteen doses of Xanax signed out but not recorded as given to the resident. On 6/27/18 at 9:33 a.m., the licensed practical nurse (LPN #1) routinely administering medications to Resident #38 was interviewed about the Dilaudid and Xanax signed out of the narcotic box but not listed as administered. LPN #1 stated Resident #38 requested the as needed Dilaudid and Xanax "pretty regular" on most days. LPN #1 reviewed with utilization count sheets and the MAR and stated she did not know why the Dilaudid and Xanax were signed out but not marked as given. LPN #1 stated medications were supposed to be recorded on the MAR at the time administered. LPN #1 stated she always documented controlled medications from the locked box on the MAR. On 6/27/18 at 9:35 a.m., the registered nurse unit manager (RN #1) was interviewed about Resident #38's Dilaudid and Xanax not marked on the MAR as given. RN #1 stated, "Looks like they [nurses] signed it [medication] out the narc [narcotic] box but did not sign off the MAR." RN #1 stated she had recently identified problems with some nurses not signing the MAR when medications were given. RN #1 stated nurses were supposed to sign off the MAR at the time medications were administered. On 6/28/18 at 8:34 a.m., RN #1 was interviewed again about lack of an administration record for multiple doses of Resident #38's Dilaudid and Xanax. RN #1 stated nurses were taught to	F 755		

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F 755	Continued From page 17	F 755		

document all medications given. RN #1 stated if a nurse signed a medication out of the narcotic box, they were expected to administer the medication and sign off the MAR. RN #1 stated she had reviewed the records and multiple nurses failed to mark doses as given on the MAR. RN #1 stated both nurses on the night shift (11:00 p.m. to 7:00 a.m.) were not marking the Dilaudid and Xanax as given even though they were signed out on the count sheets.

On 6/28/18 at 11:25 a.m., the DON was interviewed about nurses not signing medications as administered. The DON stated, "We teach them [nurses] to write on the MAR." The DON stated the facility did not have a policy specifically about writing narcotics on the administration record. When asked how they were sure the controlled medications were administered to the resident, the DON stated pain assessments for Resident #38 indicated effective pain management.

On 6/28/18 at 12:40 p.m., the facility's consultant pharmacist was interviewed by telephone about Resident #38's Dilaudid and Xanax not on the MAR. The pharmacist stated it was required for all medications given to be documented on the MAR, especially controlled medications. The pharmacist stated he "spot checks" narcotics with the MARs during his monthly reviews but he was not aware of any issues with nurses not documenting controlled medications. The pharmacist stated accountability was required for all medications given including all controlled medications.

The facility's policy titled Medications - Oral Administration Of (revised 9/22/17) included in

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F 755	Continued From page 18	F 755		

steps for medication administration, "...Chart of Medication Administration Record (MAR) according immediately following when medication is given and before proceeding to the next resident..." (sic)

The facility's policy title of Acceptance of Controlled Drug (8/24/17) stated it was policy to "ensure controlled drugs are properly accounted for in accordance with Federal Regulations." This policy stated, "Controlled dugs will be delivered to the facility by the pharmacy in a sealed, tamper proof container...Two nurses will open the controlled drug container and reconcile the controlled drugs including but not limited to: correct medication, dosage, amounts...Controlled medications are then place in medication carts by nurses...If discrepancies are found during reconciliation notify the pharmacy and the Director or Nursing. Discrepancies may include but are not limited to: missing controlled drugs, incorrect quantities, damaged containers or seals..." (sic)

The Lippincott Manual of Nursing Practice 10th edition on page 16 states regarding professional standards of care, "Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to...follow physician orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record, administer medications as ordered..." (1)

The Nursing 2017 Drug Handbook on page 1603 states concerning patient safety during drug therapy, "...Applying the nurse process

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F 755	Continued From page 19	F 755		

(assessment, nursing diagnosis, planning, intervention, and evaluation) during drug therapy enables the nurse to systematically identify the drug therapy needs of each patient, thereby reducing the number of adverse events and providing safe patient care..." Nursing steps listed for safe drug therapy included, "... Document medication administration..." (2)

The Nursing 2017 Drug Handbook on page 734 described Dilaudid (hydromorphone) as an opioid analgesic and a schedule II controlled substance used to the treatment of moderate to severe pain. Page 736 of this reference states Dilaudid has a Black Box Warning and documents, "Hydromorphone is an opioid agonist with an abuse liability similar to other opioid agonists, legal and illicit...Routinely monitor all patients for signs and symptoms of misuse, abuse, and addiction during treatment." Page 1588 of this reference states schedule II drugs have, "High abuse potential with severe dependence liability..." (2)

The Nursing 2017 Drug Handbook on page 109 describes Xanax as an anxiolytic used for the treatment of anxiety and panic disorders. Page 1588 of this reference includes Xanax as a controlled schedule IV medication with less abuse potential than schedule II or III drugs and limited dependence liability. (2)

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F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to prepare and serve food in a sanitary manner. A dietary staff member failed to follow infection control practices for proper hand hygiene during meal preparation. There was improper concentration of sanitizer in the 3-compartment sink. The finding include: On 6/26/18 at 11:15 a.m. until 11:40 a.m., kitchen staff members were observed preparing/serving food items for the lunch meal. On 6/26/18 at 11:28 a.m., the dietary manager was observed washing her hands at the prep sink. After	F 812	F812 1. Dietary staff member identified received individual re-education and competency demonstration of hand hygiene practices per standard as well as correct concentration of sanitizer utilized in the 3 compartment sink. Identified Dietary staff member provided individual re-education on regulation requirements for food prepared safe/sanitary environment. 2. Dietary Services Manager/Designee conducted Quality Observation Review of dietary staff for hand hygiene practices per standard and correct concentration of sanitizer utilization in the 3 compartment	8/1/18

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F 812	Continued From page 21 washing her hands, the dietary manager turned off the water by directly touching the faucet handles prior to drying her hands with a paper towel. The dietary manager washed her hands in this same manner three additional times during the kitchen observation, directly touching the faucet handles after washing her hands. On 6/26/18 at 11:43 a.m., the dietary manager was requested to check the sanitizer concentration in the 3-compartment sink. The testing paper made no change in color indicating a concentration of 0 to 150 ppm (parts per million) of sanitizer. The dietary manager emptied the sink and refilled it twice with sanitizer added by use of a push-button pump. The sanitizer solution failed to reach the required concentration of 150 ppm to 400 ppm with any of the refills. The dietary manager stated at this time that she was not aware of any problems with the sanitizer pump. The dietary manager stated the proper level of sanitizer was supposed to be provided with four pushes on the sanitizer pump. On 6/27/18 at 1:25 p.m., the dietary manager was interviewed about the 3-compartment sink sanitizer and hand washing technique observed in the kitchen. The dietary manager stated the vendor checked the sanitizer pump and found the pump was not dispensing the correct amount of sanitizer. The dietary manager stated the solution was supposed to be between 200 ppm and 400 ppm for proper sanitization. Concerning hand washing, the dietary manager stated hands were supposed to be dried prior to turning off the water. The dietary manager stated a paper towel was supposed to be used to touch faucet handles after washing hands.	F 812	sink. Follow up based on findings. 3. Regional Dietary Services Manager/Designee completed re-education and competency demonstration of hand hygiene practices per standard and correct concentration of sanitizer utilized in 3 compartment sink for Dietary Services Employees. Regional dietary Services Manager/Designee provided re-education for Dietary Services Employees re-education regarding regulation requirements for food prepared safe/sanitary environment. 4. Dietary Services Manager/Designee to conduct Quality Improvement Monitoring of Dietary Services Department Employees for hand hygiene practices per standard and correct concentration of sanitizer utilized in 3 compartment sink 3x/day x 1 week, 5x/week 2 weeks, weekly x 4 weeks, then monthly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 812	Continued From page 22 The facility's policy titled Hand Hygiene (effective 9/6/2016) stated concerning steps for proper hand washing, "Wet hands with water and apply soap... Create lather cleaning front and back of the hands...for a minimum of 20 seconds...Rinse hands and wrist under running water...Dry hands with paper towels...Turn faucets off with a clean paper towel...Dispose of paper towels in the trash..." The facility's policy titled "Pot Sink" (undated) documented, "All pots and large wares will be cleaned and sanitized using the pot sink...A 3-compartment sink will be set up to wash, rinse, and sanitize in the following manner...In the third compartment, sanitize with a sanitizing solution mixed at a concentration specified on the manufacturers label ...Test the chemical sanitizer concentration using an appropriate test strip." The sanitizer manufacturer's poster documented the steps for mixing of the sanitizer solution as, "Dip paper for 10 seconds...Compare colors immediately with colors on the test strip package scale...Testing solution should be between 150-400 ppm." These findings were reviewed with the administrator and director of nursing during a meeting on 6/28/18 at 1:30 p.m.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in	F 842		8/1/18

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accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

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F 842	Continued From page 24 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(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 ensure an accurate clinical record for one of 25 residents in the survey sample. Resident #83's clinical record inaccurately documented a do not resuscitate (DNR) order when the resident was actually a full code. The findings include: Resident #83 was admitted to the facility on 8/1/17 with a re-admission on 5/2/18. Diagnoses for Resident #83 included dementia, neuro-cognitive disorder, diabetes, osteoarthritis and heart failure. The minimum data set (MDS) dated 5/30/18 assessed Resident #83 with	F 842	F842 1. For Resident #83's clinical record which inaccurately documented a do not resuscitate (DNR) order when the resident was actually a full code- the Physician has written a clarification order to discontinue any previous order regarding the code status of the resident, and clearly stating that resident #83 is Full Code. 2. A review has been conducted by Director of Clinical Services/designee to ensure that charts do not express inaccurate documentation of a do not resuscitate (DNR) order when the resident is actually a full code.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495344	A. BUILDING ______ B. WING ______	C 06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 25 severely impaired cognitive skills. Resident #83's clinical record documented a physician's order dated 5/31/18 listing the resident's resuscitation status as "DNR/DNI" (do not resuscitate/do not intubate). There was no other documentation in the record regarding the resident's resuscitation status. There was no progress note indicating a discussion with the resident and/or her responsible party and no signed consent from the resident regarding the status. Resident #83's plan of care (revised 6/19/18) documented the resident's resuscitation status as "full code" indicating a requirement for resuscitation in case of cardiac arrest. On 6/28/18 at 7:50 a.m., the licensed practical nurse (LPN #1) caring for Resident #83 was interviewed about the resuscitation status. LPN #1 stated the resident was a "full code." LPN #1 state she did not know why the record documented a DNR order. On 6/28/18 at 8:11 a.m., the facility's social worker was interviewed about Resident #83. The social worker stated they had been "going round about" with Resident #83's code status. The social worker stated the resident did not want to be a DNR. The social worker stated she did not know why the physician entered an order for the DNR status. On 6/28/18 at 8:18 a.m., the registered nurse unit manager (RN #1) was interviewed about the DNR order on record for Resident #83. RN #1 stated the resident wanted to discuss the situation with her family before she made the decision for the	F 842	3. In-servicing will be provided to the staff regarding proper documentation of a do not resuscitate (DNR) order when the resident is actually a full code. A random weekly review will be conducted by the DCS/designee weekly for three (3)months to ensure that charts do not express inaccurate documentation of a do not resuscitate (DNR) order when the resident is actually a full code. 4. Results of the reviews will be discussed by the Administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3)months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.	

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F 842	Continued From page 26 DNR order. RN #1 stated the "yellow" DNR form was in a folder for the physician and had not been completed with permission from the resident and/or her responsible party. RN #1 stated the resident was considered a "full code" until the physician and family completed the required paperwork. RN #1 stated the DNR order in the record was inaccurate and needed to be discontinued. These findings were reviewed with the administrator and director of nursing during a meeting on 6/28/18 at 1:30 p.m.	F 842		