STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495409	A. BUILDING _____ B. WING _____	C 09/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABINGDON HEALTH CARE LLC	15051 HARMONY HILLS LANE ABINGDON, VA 24211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 09/06/17 through 09/07/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during this survey. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 116 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents #1 through #21) and 6 closed record reviews (Residents #22 through #27).	F 000		
F 285 SS=D	PASRR REQUIREMENTS FOR MI & MR CFR(s): 483.20(e)(k)(1)-(4) (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual	F 285		10/6/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/29/2017

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disability.

(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:

(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services; or

(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

(2) Exceptions. For purposes of this section-

(i)The preadmission screening program under

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paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-

(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and

(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

(3) Definition. For purposes of this section-

(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).

(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.

(k)(4) A nursing facility must notify the state mental health authority or state intellectual

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F 285	Continued From page 3 disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to obtain a level I PASRR (preadmission assessment and Resident review) for 1 of Residents, Resident #12 The findings included: For Resident #12 the facility staff failed to obtain a level I PASRR within 30 days of admission. Resident #12 was admitted to the facility on 05/15/15. Diagnoses included but not limited to dementia, diabetes mellitus type II, epilepsy, coronary artery disease, anxiety, hypertension, hyperlipidemia, depression and dysphagia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 06/07/17 coded the Resident as 6 of 15 in section C, cognitive status. Resident # clinical record was reviewed on 09/07/17. The surveyor could not locate a level I PASRR. The surveyor spoke with the DON (director of nursing) on 09/07/17 at approximately 1345 regarding the location of the PASRR and the DON stated that the PASRR for Resident #12 could not be located. The concern of the missing PASRR was discussed with the administrative team during a meeting on 09/07/17 at approximately 1655.	F 285	F285 1.It is duly noted Resident#12 did not have a level 1 PASRR completed within 30 days of admission. Resident#12 PASRR was obtained on 9/25/17. 2.Any resident admitted to facility is at risk for not having a level 1 PASRR completed within 30 days of admission. An audit of all residents admitted to center on or after September 1, 2017 will be conducted to determine if others are at risk for not having PASRR completed within 30 days of admission. A PASRR will be completed for any at risk resident identified. 3.Administrator or designee will educate admission and social services staff on the requirements of completing PASRRS. 4.Social Services Coordinator or designee will audit all new admissions daily (M-F) x4 weeks, then weekly x8 weeks to determine those residents requiring PASSR and ensure completion. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5.Date of Compliance 10-6-2017	

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F 285	Continued From page 4 No further information was provided prior to exit.	F 285		
F 309 SS=E	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 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	F 309		10/6/17

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F 309	Continued From page 5 preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide the highest practical well-being to 1 of 27 residents in the survey sample (Resident #17). The findings included: The facility staff failed to document on the dialysis communication sheets prior to Resident #17 leaving the facility and then not following up with dialysis to obtain documentation once the resident was returned back to the facility. Resident #17 was originally admitted to the facility on 2/18/13 and was readmitted to the facility on 7/11/17 with the following diagnoses of, but not limited to high blood pressure, thyroid disorder, Manic Depression, psychotic disorder, Schizophrenia, end stage renal disease and dependence on renal dialysis. The resident was coded on the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/18/17 with a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #17 was also coded as requiring extensive assistance of 1 staff member for eating, personal hygiene and bathing. The surveyor reviewed the clinical record of Resident #17 on 9/7/17. It was noted by the surveyor that for the months of July, August and September, 2017 the communication sheets that goes with the resident to dialysis was not completely filled out either by the nursing facility staff or by the dialysis center staff. The missing documentation was either missing pre and post	F 309	F309 1.It is duly noted that facility failed to complete all sections of dialysis communication forms to include weights and vital signs prior to Resident#17 leaving facility. It is also duly noted that facility did not follow up with dialysis center to obtain missing documentation to include weights and vital signs upon return of Resident#17 to facility. Resident #17 record has been reviewed and revised to include hemodialysis treatment forms obtained from dialysis center for the months of July 2017, August 2017, and September 2017 that include pre and post dialysis treatment weights and vital signs. 2.Any resident receiving hemodialysis is at risk for not receiving the highest level of practical well-being related to incomplete dialysis communication forms. An audit of all residents currently receiving hemodialysis will be completed to identify if others are at risk for missing documentation. Any discrepancies will be corrected as identified. 3.DON or designee will educate licensed staff on documentation requirements per Dialysis Monitoring and Communication Policy to include completion of the dialysis communication form that is sent with the resident to the dialysis center and review of the communication form upon return to	

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F 309	Continued From page 6 dialysis weights as well as vital signs before and after dialysis. At 1 pm, on 9/7/17, the surveyor showed the director of nursing the missing documentation on the dialysis communication sheets. The director of nursing stated, "These areas should be filled out by our staff and then these areas should be filled out by the dialysis staff. Let me call the dialysis center and see what documentation they have on this resident." At 1:45 pm, the administrative team was notified of the above documented findings by the surveyor in the conference room. The surveyor requested a copy of the facility's policy regarding residents receiving dialysis. The director of nursing returned to the surveyor at 4:30 pm with copies of the resident's "Hemodialysis Treatment" form from the dialysis center. The time and stamp mark on the copies provided to the surveyor were 9/7/17 at 16:16 (4:16 pm). The treatment forms had documentation of the pre and post weights and of the vital signs of the resident for the months of July, August and September, 2017. The director of nursing stated, "I had to call the dialysis center and get them to fax these to me." The surveyor also received the policy that the facility has for residents receiving dialysis. Under Procedure, it read in part " ...6. Complete the Dialysis Communication Form and send with the resident to the Dialysis Center. Review the communication form on return to the nursing home for any changes in condition, medication or treatment ..." No further information was provided to the	F 309	the center. This would also include review for any changes in condition, medication, or treatment. 4.DON or designee will audit residents receiving hemodialysis daily (M-F) x4 weeks, then weekly x8 weeks to ensure completion of dialysis communication forms on transfer to dialysis center and upon return. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5.Date of compliance 10-6-2017	

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F 309	Continued From page 7 surveyor prior to the exit conference on 9/7/17.	F 309		
F 365 SS=D	FOOD IN FORM TO MEET INDIVIDUAL NEEDS CFR(s): 483.60(d)(3) (3) Food prepared in a form designed to meet individual needs; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to meet the resident's individual needs in regards to form of food served to 1 of 27 residents in the survey sample (Resident #1). The findings included: The facility staff failed to meet the resident's individual needs in regards to form of food served to Resident #1 for breakfast during a meal observation made by the surveyor on 9/7/17. Resident #1 was admitted to the facility on 2/13/17 with the following diagnoses of, but not limited to high blood pressure, dementia, Parkinson's disease, Psychotic Disorder and osteoarthritis. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/21/17, Resident #1 was coded as having a BIMS (Brief Interview for Mental Status) score of 10 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 2 staff members for dressing and toilet use and extensive assistance of 1 staff member for personal hygiene. Resident #1 was also coded as requiring limited assistance of 1 staff member to assist with eating. The surveyor made a meal observation on 9/7/17	F 365	F365 1.It is duly noted that Resident#1 was served a biscuit with whole sausage patty, which is not consistent with Resident #1 physician diet order for mechanical soft/ground meat as outlined in the 2567. Staff that deliver meal trays have been in-serviced to follow the tray card to ensure the correct diet is served to each resident. 2.Any resident with a physician□s order for a mechanically altered diet is at risk for not receiving food in the form to meet individual needs. An audit of residents with physician orders for a mechanically altered diet will be conducted to ensure accuracy of tray card and that correct diet is served. Any discrepancies will be corrected as identified. 3.Administrator or designee will educate and in-service staff that participate in meal delivery on tray identification policy and delivery of tray to ensure each residents□ tray card is read and that the resident is served correctly per physician ordered diet.	10/6/17

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F 365	Continued From page 8 at 8:20 am in the Martha's Ridge dining room in which Resident #1 was seated to have breakfast. The resident was served a breakfast tray that consisted of pieces of biscuits with gravy over it, ground up sausage and scrambled eggs and oatmeal. The resident was assisted by having her tray set up for her. The surveyor observed the resident sitting with a blank stare looking at her breakfast. The surveyor spoke to the resident and the resident replied "Hi". At 8:30 am, the surveyor observed the assistant administrator go over to Resident #1 and speak to the resident then verbally encourage the resident to eat her biscuits and gravy but did not assist in feeding the resident. The resident continued to sit and look at breakfast tray in front of her. At 8:32 am, CNA (certified nursing assistant) #1 came over to Resident #1 and began talking to the resident about eating breakfast and fed the resident (1) bite of biscuits and gravy and (1) bite of sausage which was in a grounded texture. At 8:40 am, CNA #1 came back to Resident #1 and encouraged her to eat some more of her breakfast. CNA #1 attempted to feed the resident a bite of biscuits and gravy but resident refused. At 8:42 am, CNA #1 went over to the tray line where breakfast was being served in the dining room and asked for a biscuit and piece of sausage for Resident #1. The CNA returned to Resident #1's table and sat down a whole biscuit and a whole piece of sausage in front of the resident and encouraged the resident to try eating this. The surveyor observed the resident attempting to feed herself. The resident took a	F 365	4.The Dietary Manager or designee will conduct audits on three meals daily (M-F) for one week, then a sample of five residents in each serving area to be conducted for one meal x5 weeks, then monthly x2 to ensure accuracy of resident□s diet. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5.Date of compliance 10-6-2017	

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F 365	Continued From page 9 bite from the biscuit and then a bite from the sausage patty. CNA #1 left the table with Resident #1 and went to help another resident to eat. The surveyor conducted a clinical record review of Resident #1's electronic clinical record. It was noted by the surveyor that Resident #1's diet order by the physician was to be on a "Regular Diet, mech (mechanical) soft (ground meat) texture, Thin consistency ..." The physician had written to begin this diet on 2/14/17. At 1:40 pm, the surveyor interviewed the Consultant Dietician #1 in the conference room. The surveyor showed the Consultant Dietician #1 the physician order in the electronic record as being for a Regular diet, mechanically soft (ground beef) texture. The surveyor asked if the resident should have received a biscuit and a whole piece of sausage for breakfast without it being a ground meat texture. The Consultant Dietician #1 stated, "The resident is allowed a regular diet but everything has to be mechanically soft with ground beef texture. The biscuit would be ok but the sausage patty needed to be ground meat texture." The administrative team was notified of the above observations and documented findings as above on 9/7/17 at 1:45 pm. No further information was provided to the surveyor prior to the exit conference on 9/7/17.	F 365		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 441		10/6/17

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(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;

(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

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F 441	Continued From page 11 (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 a medication pass and pour observation, staff interview, and facility document review, the facility staff failed to follow infection control policy and procedures during a medication pass on 1 of 3 units. The findings include: The facility staff failed to follow infection control policy and procedure during a medication pass on 9/7/17 at 7:30 a.m. conducted on one unit in the facility.	F 441	F441 1.It is duly noted that LPN#1 failed to follow infection control policy and procedure when lancet dropped on floor was used to obtain resident blood sugar as detailed in the 2567. LPN#1 has been educated on the General Infection Control policy and guidelines. 2.Any resident with a physician order for accuchecks is at risk during medication administration if licensed staff fail to follow	

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F 441	Continued From page 12 A staff nurse (LPN#1) was observed on the ART unit to perform accuchecks (blood sugar monitoring) on several residents on the unit. LPN#1 was observed to enter a resident's room carrying equipment to perform a blood sugar check. The nurse carried a glucometer and an accucheck lancet. LPN#1 was observed to drop the lancet on the floor and pick it up and use it on the resident to obtain a blood sample. LPN#1 was interviewed and stated she thought it was ok to use because the needle was not exposed. The infection control policy was obtained from the director of nursing on 9/7/17. The General Infection Control Policies was reviewed. The policy stated , "no item (clean or soiled linen, clothing, personal items,etc) are to touch the floor". The administrator, assistant administrator, director of nursing, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 9/7/17 at 1:05 p.m.	F 441	infection control policies and guidelines. 3.DON or designee will educate licensed staff on general infection control policy and procedures as related to medication administration and accuchecks. 4.DON or designee will audit 5 residents with physician orders for accuchecks daily(M-F)x4 weeks,then weekly x8 weeks to ensure general infection control policy is followed per protocol. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5.Date of compliance 10-6-2017	
F 502 SS=D	ADMINISTRATION CFR(s): 483.50(a)(1) (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	F 502		10/6/17

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F 502	Continued From page 13 by: Based on staff interview and clinical record review the facility staff failed to obtain a physician ordered laboratory test for 1 of Residents, Resident #12 The findings included: For Resident #12 the facility staff failed to obtain the physician ordered lab for a Keppra level and HgA1C (hemoglobin A1C- a test for diabetes). Resident #12 was admitted to the facility on 05/15/15. Diagnoses included but not limited to dementia, diabetes mellitus type II, epilepsy, coronary artery disease, anxiety, hypertension, hyperlipidemia, depression and dysphagia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 06/07/17 coded the Resident as 6 of 15 in section C, cognitive status. This is a quarterly MDS. Resident #12's clinical record was reviewed on 09/06/7. It contained a signed physician's order dated which read in part "Keppra level, HgA1C q (every) 3 months". The surveyor could not locate the results of the test for the month of December 2016. The surveyor spoke with the DON (director of nursing) on 09/07/17 at approximately 1345 regarding the missing test results. DON stated that she had done a complete chart audit, but did not go back past January 2017. She also stated that she could not locate the results for December 2016. The concern of the missing test results was	F 502	F502 1.It is duly noted that Resident#12 did not have Keppra and HgAIC labs drawn in December 2016 per physician order as detailed in the 2567. Resident#12's MD and RP have been notified and lab error investigation completed. 2.Any resident with physician order for labs is at risk if labs are not obtained per physician order. An audit of lab orders for previous 30 days will be conducted to verify completion and presence of results. Any discrepancies will be corrected as identified. 3.DON or designee will educate licensed staff on the importance of obtaining labs as ordered by physician. 4.DON or designee will audit lab orders and results daily (M-F) x4 weeks, then weekly x8 to ensure labs are obtained per physician order. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5.Date of compliance 10-6-2017	

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F 502	Continued From page 14 discussed during a meeting with the administrative staff on 09/07/17 at approximately 1655. No further information was provided prior to exit.	F 502		
F 514 SS=E	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (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 (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	F 514		10/6/17

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F 514	Continued From page 15 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 Resident interview, staff interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 4 of 27 Residents, Residents #6, #20, #2, and #5. The findings included. 1. For Resident #6, documentation in the clinical record indicated the Resident had received the narcotic pain medication hydrocodone-acetaminophen 19 times for the months of August and September 2017. Resident #6 stated to the surveyor that she had not had any pain medication in a while. The record review revealed that Resident #6 had been admitted to the facility 03/21/17. Diagnoses included, but were not limited to, left below knee amputation, dysphagia, PVD (peripheral vascular disease), dementia, and stage 3 kidney disease. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/26/17 included a BIMS (brief interview for mental status) summary score of 13 out of a possible 15 points. Section J (health conditions) was coded to indicate the Resident frequently had pain that made it hard for her to sleep. The numeric rating on a scale of 1-10 was documented as a 4.	F 514	F514 1.(a) It is duly noted that the staff failed to maintain a complete and accurate medical record for Resident#6 as outlined in the 2567. MD was notified on 9/11/17 of Resident #6 and an order for a urine drug screen was obtained. Disciplinary action was taken associated with LPN#1. (b)It is duly noted that staff failed to ensure a complete and accurate clinical record for Resident#20 as outlined in the 2567. Resident #20 no longer resides in the facility. (c)It is duly noted that staff failed to maintain a complete and accurate clinical record for Resident#2 as outlined in the 2567. (d)It is duly noted that facility staff failed to ensure physician□s orders were complete and accurate for Resident #5 as outlined in the 2567. MD was notified on 9/7/17 and a clarification order was obtained. 2.(a) Any resident with physician orders for PRN pain medication is at risk for receiving PRN pain medication without attempt of non-pharmacological intervention first.	

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The Residents CCP (comprehensive care plan) included the focus area "Risk for unresolved pain related to recent surgery, CAD, kidney impairment, anemia, PVD, Gerd, others." Date initiated 04/21/17.

The Residents current POS (physician order sheet) included orders for the pain medications acetaminophen 650 mg 1 tab by mouth every 6 hours as needed for general discomfort and for the narcotic hydrocodone-acetaminophen 5-325 1 tablet by mouth every 6 hours as needed for pain. This POS had been signed by the physician on 07/03/17.

A review of the Residents eMARs (electronic medication administration records) for August 2017 included documentation to indicate that Resident #6 had been administered the narcotic pain medication hydrocodone-acetaminophen 5-325 17 times and that LPN (licensed practical nurse) #1 had administered this medication 14 of these 17 times. For September the clinical record included documentation to indicate the hydrocodone-acetaminophen 5-325 had been administered 2 times both of these administration times were documented by LPN #1.

There was no documentation to indicate the facility had provided any prn (as needed) acetaminophen to Resident #6.

Resident #6 was observed by the surveyor in the hallway and in her room of the facility. During these observations the Resident was alert and orientated and did not complain of any pain.

On 09/07/17 at approximately 12:45 p.m. the surveyor spoke with Resident #6 in her room.

(b)Any new admission is at risk for lacking documentation on admission body assessment. An audit of all new admissions on or after September 1, 2017 will be conducted to determine if others are lacking documentation on admission body assessment. Any discrepancies will be identified.

(c)Any resident with behaviors receiving PRN medication is at risk for lacking documentation of physician notification.

(d)Any new admission to center is at risk for physician□s orders not to be complete and accurate. An audit of all new admission on or after September 1, 2017 will be conducted to determine if others are at risk for incomplete or inaccurate physician orders. Any discrepancies will be identified.

3.(a)DON or designee will educate licensed staff on implementation of non-pharmacological interventions prior to administration of PRN pain medication.

(b)DON or designee will educate licensed staff on admission assessment documentation requirements to include skin assessment policy and procedure for documenting any findings on admission in the EMR.

(c)DON or designee will educate licensed staff on requirements for physician notification including appropriate corresponding documentation in the resident clinical record.

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F 514	Continued From page 17 When asked about the pain medication she had been administered and if the facility provided any non-pharmacological interventions prior to administering such as repositioning etc...Resident #6 stated they did not but she had not taken any pain medication in a while. During a meeting with the administrative staff on 09/06/17 at approximately 1:45 p.m. the administrative staff was asked if Resident #6 was alert and orientated to which the DON (director of nursing) replied yes. The administrative staff was then made aware that Resident #6 had verbalized to the surveyor that she had not had any pain medication in a while but the clinical record included documentation to indicate the Resident had received the narcotic pain medication hydrocodone-acetaminophen 5-325 17 times in August and 2 times in September. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. The facility staff failed to ensure a complete and accurate clinical record for Resident #20. Resident #20 was admitted to the facility on 8/31/17 with diagnoses of cholecystectomy, diabetes, and hypertension. The Minimum Data Set was not complete at the time of the survey. The resident was identified by staff as alert and oriented. Resident #20 was interviewed on 9/7/17 at 3:15 p.m. The resident stated she was admitted for therapy following her gall bladder surgery. The clinical record was reviewed. The nursing	F 514	(d)DON or designee will educate licensed staff on admission medication reconciliation to include medication, dosage, route, and frequency. 4.(a) DON or designee will conduct daily audits (M-F)x4 weeks, then weekly x8 of 3 residents with BIMS >12 with orders for PRN pain medication to validate administration and to ensure documentation of non-therapeutic interventions prior to administration. (b)DON or designee will audit new admissions daily (M-F) x4 weeks, then weekly x8 weeks to ensure complete and accurate body assessment documentation. (c)DON or designee will audit 24 hour report to identify any resident with behaviors requiring physician intervention daily (M-F) x4 weeks, then weekly x8 weeks to ensure appropriate documentation of physician notification. (d)DON or designee will audit 3 residents with new orders daily (M-F) x4 weeks, then weekly x8 weeks to ensure orders are reconciled to include medication, dosage, route, and frequency. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5.Date of compliance 10-6-2017	

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admission assessment was reviewed. The nurse failed to document the presence of a surgical wound upon admission at approximately 2:00 p.m. on 8/31/17. The nurse documented on the Body Assessment of the admission that there were no wounds, skin tears, bruises, and /or surgical incisions present.

The physician documented on his admission history and physical that the resident presented for aftercare for a cholesystectomy.

A skilled nursing summary note at 10:54 p.m. noted the "skin not intact. Surgical incision, not fully healed present. No signs or symptoms of wound infection or inflammation."

The corporate nurse consultant reviewed the clinical record and agreed the nurse should have documented the presence of the surgical wound upon admission.

The administrator, assistant administrator, director of nursing, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 9/7/17 at 1:05 p.m.

3. The facility staff failed to maintain a complete and accurate clinical record for Resident #2.

Resident #2 was admitted to the facility on 12/21/15 with the following diagnoses of, but not limited to dysphagia, stroke, retention of urine, thyroid disorder, orthostatic hypotension and muscle weakness. The resident was coded on the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/22/17 as having a BIMS (Brief Interview for Mental Status) score of 10 out of a possible score of 15.

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Resident #1 was also coded as requiring extensive assistance of 2 or more staff members for dressing, toilet use and personal hygiene.

A clinical record review was performed by the surveyor on 9/6/17 and 9/7/17. It was noted by the surveyor that a telephone order had been written on Resident #2's electronic clinical record which was dated and timed for 6/20/17 at 1700 (5 pm) that stated, "Ativan 0.5 mg (milligram) po (by mouth) x (times) 1 dose now." The surveyor also reviewed the MAR (Medication Administration Record) record for the month of June, 2016 and the surveyor noted the following documented as being given to Resident #2 on 6/20/17 at 1727 (5:27 pm) which stated, "Ativan 0.5 mg by mouth x 1 dose now."

The surveyor reviewed the nursing notes for 6/20/17 at 16:15 (4:15 pm) which stated , " ...Very agitated, yelling, wanting other residents to get her out of here, rolling around in w/c (wheelchair) and hitting other residents with her w/c. Unable to redirect or reorient resident, Vistaril 25 mg given per order."

The next nursing note was dated and timed for 6/20/17 at 1712 (5:12 pm) which stated, "New order received and noted daughter ____ (Name of daughter) here and aware and voices understanding. Daughter _____ (Name of daughter) ask for resident to have Ativan for her behavior."

The administrative team was notified of the above documented findings by the surveyor on 9/7/17 at 1:45 pm. The surveyor asked the director of nursing if the physician had been called by the facility staff and notified of the resident's

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behaviors and of the resident had already received Vistaril prior to the staff notifying the physician. The director of nursing stated, "I feel confident that the nurse did call the physician and report this to him because the nurse has to have a code to unlock the Stat box to be able to give a medication like this. It just wasn't documented completely."

No further information was provided to the surveyor prior to the exit conference on 9/7/17.
4. For Resident #5 the facility staff failed to ensure physician's orders were complete and accurate

Resident #5 was admitted to the facility on 11/15/16. Diagnoses included but not limited to anemia, hypertension, hip fracture, Alzheimer's disease, dementia, schizophrenia, and dysphagia.

The most recent MDS (minimum data set) with an ARD) assessment reference date of 07/10/17 coded the Resident as having problems with both long and short term memory problems, and severely impaired cognitive skills for daily decision making in section C, cognitive status. This is a quarterly MDS.

Resident #5's clinical record was reviewed on 09/06/17. It contained a signed physician's order summary which read in part "Folic acid tablet-give 1 tablet by mouth one time a day for supplement". The original order date was 11/15/16 and there was no dosage amount indicated in the order.

Surveyor spoke with the pharmacist via telephone on 09/07/17 at approximately 0850 regarding Resident #5's folic acid order. Pharmacist stated

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that the order should read "Folic Acid 1 mg". Pharmacist also stated that the order had been clarified on 11/15/16 by LPN (licensed practical nurse) #1.

Surveyor spoke with LPN #2 on 09/07/17 at approximately 0915 regarding Resident #5's folic acid order. Surveyor asked LPN #2 how she knew how much folic acid to administer, and LPN #2 stated "the package from the pharmacy is 1mg and that is what the order is for". LPN #2 then pulled the order and looked at it, then stated "You are right, it doesn't say how much, I'll get that clarified".

The concern of the incomplete order was discussed during a meeting with the administrative staff during a meeting on 09/07/17 at approximately 1655.

No further information was provided prior to exit.