| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | Initial Comments<br><br>An unannounced biennial State Licensure survey was conducted 8/28/17 through 8/30/17. Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities.<br><br>The census in this 92 certified bed facility was 81 at the time of the survey. The survey sample consisted of 14 current resident reviews (Residents 1 through 14) and 5 closed record reviews (Residents 15 through 19). | F 000 | | |
| F 001 | Non Compliance<br><br>The facility was out of compliance with the following state licensure requirements:<br><br>This RULE: is not met as evidenced by:<br>12 VAC 5 - 371 - 140 E 3<br><br>Based on staff interview, facility document review and employee record review, it was determined that the facility staff failed to follow their policies and procedures for obtaining pre-employment screening for 17 of 25 employee record reviews.<br><br>The facility staff failed to have evidence of criminal background checks, license verifications or references completed prior to hire for 17 of 25 employee record reviews.<br><br>The findings include:<br><br>Twenty-five employee records were reviewed. The following is a list of items that were missing or not completed timely for the following employee records:<br><br>- Employee Record #2 - (dietary manager) hire | F 001 | F001 – Employee Recrods, Abuse neglect, etc. policies<br><br>1. Records were corrected.<br>2. All residents have the potential to be affected By this deficient practice. 100% audit of current employees' licenses, criminal Criminal background checks, drug screen and References completed. Corrected as needed.<br>3. Human resources and Dept Managers were educated On pre-employment requirements by Administrator/designee.<br>4. Audit of new employee personnel files 5 times a week By administrator/designee for 12 weeks for license verification, Criminal background screen, references, drug screen monthly for 3 months by Administrator/designee. Results of audits will be taken to QAPI monthly for 3 months for review and revision as needed.<br>5. 10/4/2017 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Tyler, LNHA — TITLE: Administrator — (X6) DATE: 9-22-17

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| F 001 | Continued From Page 1<br><br>date of 4/12/16. A criminal background check was not completed.<br>- Employee Record #5 - (business office manager) hire date of 9/26/16, a criminal background check was not completed.<br>- Employee Record #6 - LPN (licensed practical nurse), hire date of 2/15/17, a professional license was not verified.<br>- Employee Record #8 - RN (registered nurse), a hire date of 3/1/17, a professional license was not verified and references were not in the file.<br>- Employee Record #9 - CNA (certified nursing assistant), hire date of 3/28/16, a criminal background check was requested on 3/30/16, there was no returned background check.<br>- Employee Record #10 - Housekeeping - hire date of 5/3/17 - no references found in record.<br>- Employee Record #12 - LPN - hire date of 3/8/17 - No license verification of license and no references in the file.<br>- Employee Record #15 - RN (director of nursing) hire date of 11/9/16 - No license verification.<br>- Employee Record #16 - LPN - hire date of 8/31/16 - Criminal background check dated 10/4/16. Not within 30 days of hire.<br>- Employee Record #17 - therapy, hire date of 4/28/17 - no criminal background check done within 30 days of hire. Documentation of one done on 8/14/17.<br>- Employee Record #18 - RN (director of nursing) hire date of 3/1/17 - no license verification.<br>- Employee Record #19 - LPN - hire date of 4/20/16 - criminal background check done 11/22/16, license verification done 6/28/17.<br>- Employee Record #21 - dietary - hire date of 3/11/16 - criminal background check completed 11/6/15.<br>- Employee Record #23 - therapy - hire date of 3/22/17 - criminal background check completed on 7/13/17 and license verification done on 6/28/17. | F 001 | | |

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| F 001 | Continued From Page 2<br><br>- Employee Record #24 - Payroll/accounts payable - hire date of 6/29/17 - criminal background check dates were illegible.<br>- Employee Record #25 - LPN - hire date of 8/24/16 - no criminal background check in file and no license verification.<br><br>An interview was conducted with other staff member (OSM) #6, the payroll/accounts payable staff member, on 8/30/17 at 8:47 a.m. The files above were reviewed. OSM #6 stated that the ADON (assistant director of nursing) had the nurse's and CNA licenses. She stated she would check on the above list.<br><br>OSM #6 returned on 8/30/17 at 12:15 p.m. She stated the following regarding each of the above:<br><br>Employee Record #2 - criminal background check was completed yesterday (8/29/17)<br>Employee Record #5 - criminal background check was completed yesterday (8/29/17)<br>Employee Record #6 - license was rerun today (8/30/17)<br>Employee Record #8 - references were not found and the license verification could not be located - rerun today (8/30/17)<br>Employee Record #9 - criminal background check not returned from the police. When asked if that should have been followed up on, OSM #6 stated, "That was before my time and yes it should have been followed up on."<br>Employee Record #10 - the previous housekeeping manager threw the application away in the trash and references were not completed.<br>Employee Record #12 - Verified that the items were missing.<br>Employee Record #15 - license was rerun 8/30/17. No longer an employee.<br>Employee Record #16 - verified above | F 001 | | |

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| F 001 | Continued From Page 3 | F 001 | | |

information.
Employee Record #17 - I ran the background check when I received all of the therapy files. Done as above.
Employee Record #18 - I ran the license verification today. No record of it being done.
Employee Record #19 - Verified that the items were missing.
Employee Record #21 - the background check was done 11/6/15. This was a rehire on 3/11/16. When asked if the background check needed to be redone upon rehire, OSM #6 stated, "Yes, we have to do it again."
Employee Record #23 - I ran the background check when the therapy files arrived on site.
Employee Record #24 - I reran it today due to it being illegible
Employee Record #25 - "This was a rehire. Last completed background check dated 8/25/13. I sent it in today."

The facility policy, "Virginia Resident Abuse Policy" documented in part, "Procedure: 1. Screening - facility will not employ or otherwise engage individuals who have been found guilty of abuse, neglect, or mistreatment of residents by a court of law, had a finding of abuse, neglect, mistreatment, exploitation, involuntary seclusion and/or misappropriation of property reported into a state nurse aide registry, or had a disciplinary action taken against a professional license by a state licensure body as a results of a finding of abuse, neglect or mistreatment of residents or a finding of misappropriation of property. It is the policy of the Facility to undertake background checks to all employees and to retain on file applicable records of current employees regarding such checks. a. The facility will do the following prior to hiring a new employee: iii. Check with all applicable licensing and certification authorities to ensure that employees hold the requisite license and/or

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| F 001 | Continued From Page 4<br><br>certification status to perform their job functions and have no disciplinary action as a result of abuse or neglect."<br><br>The administrator was made aware of the above concern on 8/30/17 at 1:30 p.m.<br><br>No further information provided prior to exit.<br><br>12 VAC 5 - 371 - 220 H - cross references to Federal Tag # 157<br><br>12 VAC 5 - 371 - 140 E 3 - cross references to Federal Tag #226<br><br>12 VAC 5 - 371 - 250 A - cross references to Federal Tag #278<br><br>12 VAC 5 - 371 - 250 F - cross references to Federal Tag # 280<br><br>12 VAC 5 - 371 - 220 B - cross references to Federal Tag #281<br><br>12 VAC 5 - 371 - 220 B - cross references to Federal Tag #309<br><br>12 VAC 5 - 371 - 340 - cross references to Federal Tag #364<br><br>12 VAC 5 - 371 - 340 - cross references to Federal Tag #371<br><br>12 VAC 5 - 371 - 180 C - cross references to Federal Tag #441<br><br>12VAC5-371-300. Pharmaceutical services - cross reference to F431. | F 001 | | |

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| F 001 | Continued From Page 5<br><br>12VAC5-371-360. Clinical records - cross reference to F514.<br><br>12VAC5-371-370. Maintenance and housekeeping - cross reference to F465<br><br>12VAC5-371-240 Physician Services - Cross reference to F155<br><br>12VAC5-371 270 Social Services - Cross reference to F250<br><br>12VAC5 - 371-250 Resident assessment and Care Planning- Cross reference to F279, F280, F323<br><br>12VAC5-371-200 Director of Nursing- Cross reference to F282<br><br>12VAC5-371-360 Clinical Records - Cross reference to F507, F515 | F 001 | | |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid abbreviated standard survey was conducted 8/28/17 through 8/30/17. A Complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.<br><br>The census in this 92 certified bed facility was 81 at the time of the survey. The survey sample consisted of 14 current resident reviews (Residents 1 through 14) and 5 closed record reviews (Residents 15 through 19). | F 000 | | |
| F 155 SS=D | 483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES<br><br>483.10<br>(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.<br><br>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.<br><br>(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br><br>(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. | F 155 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Pyle, NHA | TITLE: Administrator | (X6) DATE: 9-22-17

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 155 | Continued From page 1<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br><br>(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.<br><br>(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.<br><br>(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.<br><br>483.24<br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to clarify the code status for one of 19 residents in the survey sample, Resident #3. | F 155 | F155 – Right to refuse; formulate advance directives<br><br>1. Resident #3's advanced directive was Reviewed with resident, MD and RP and clarification placed in clinical record care plan updated.<br>2. All residents have the potential to be affected by this deficient practice. 100% audit of current residents' code status completed.<br>3. Social service dept and licensed nurses nursing educated on ensuring code status accuracy by administrator/designee..<br>4. An audit of new admissions/readmissions will be conducted 5 times a week by Unit managers/designee for accurate code status. Current residents will have code status reviewed with significant change, quarterly and annual MDS by social services for any code status change. Audits will be completed for 12 weeks. Results of audits will be taken to QAPI monthly for 3 months for review and revision as needed.<br>5. 10/4/2017 | |

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The facility staff failed to clarify Resident #3's code status on re-entry to the facility on 7/6/17, resulting in conflicting documentation as to whether or not Resident #3 was a DNR (do not necessitate) or a full code.

The findings include;

Resident #3 was admitted to the facility on 2/14/17, with a readmission on 7/6/17, with diagnoses that included, but were not limited to; dysphagia (difficulty with swallowing), diabetes, cardiac arrhythmia (abnormal heart beat), low blood pressure, neuropathy (damaged nerves that cause numbness and pain in the feet), enlarged prostate gland and cachexia (a wasting disease with weight loss and muscle atrophy).

Resident #3's most recent MDS (minimum data set) was a 30-day assessment with an ARD (assessment reference date) of 8/3/17. Resident #3 was coded as scoring a six out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating that the resident was severely impaired with cognition.

A review of Resident #3's Admission Notification Form completed by OSM (other staff member) #5, the admissions director revealed, in part, the following documentation; "Special Equipment /Needs/ Notes: FULL CODE. Responsible Party Name and Phone: Self."

A review of Resident #3's hospital history and physical dated 7/1/17 revealed, in part, the following documentation: "Code Status: Patient Code Status: Full Code."

A review of Resident #3's Admission Record (face

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sheet) revealed, in part, the following documentation; "Advance Directive: DNR."

A review of Resident #3's admission assessment dated 7/6/2017 at 18:26 (6:26 p.m.) revealed, in part, the following documentation; "Code Status: DNRCC (do not resuscitate comfort care). Advanced Directives were explained. Oriented to Person, Place."

A review of Resident #3's clinical record revealed, in part, the following physician order signed by ASM (administrative staff member) #4, the nurse practitioner, on 7/10/17; "7/6/2017 18:29 (6:29p.m.) Communication method: Verbal. Order Summary: DNR (do not resuscitate)."

Further review of Resident #3's clinical record revealed a Durable Do Not Resuscitate Order document dated 7/8/2017 that contained Resident #3's full name. The DDNR document was not completed to determine Resident #3's wishes; the document was signed by a physician from the hospital and there was no signature by Resident #3 or a responsible party.

A review of Resident #3's comprehensive care plan dated 7/6/17 revealed the following documentation; "Focus: Code Status: Resident / Responsible party has chosen Full Code. Date Initiated: 7/7/2017. Goal: Resident's / Responsible party code status wish will be honored daily through next review. Date Initiated: 7/7/2017. Interventions: Notify physician of any changes. Date Initiated: 7/7/2017."

On 8/29/17 at 4:50 p.m. an interview was conducted with LPN (licensed practical nurse) #10, a floor nurse taking care of Resident #3.

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LPN #10 was asked what Resident #3's code status was. LPN #10 reviewed Resident #3's clinical record via the computer software program, Point Click Care, and stated, "He (Resident #3) is DNR." When asked if that was the quickest way to determine the code status of a resident, LPN #10 stated, "We just look in the computer but we also have a book at the nurses' station that indicates the code status on their face sheets."

This surveyor reviewed the book referred to by LPN #10 and there were no face sheets for Resident #3 in the book.

On 8/29/17 at 5:45 p.m. an end of day meeting was held with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #2 was asked to describe the process followed when residents change from being a full code to a DNR. ASM #2 stated, "The nurse practitioner or physician meet with the resident and/ or the responsible party to discuss the change requested. Both the resident/responsible party and the physician / nurse practitioner would sign the form, the information would be updated electronically into the computer system (point click care) and the care plan would be updated." ASM #1 and ASM #2 were made aware that Resident #3's care plan and admission documentation state that Resident #3 is a full code and the electronic information the nursing staff refer to documents that Resident #3 is a DNR.

On 8/30/17 at 10:00 a.m. an interview was conducted with OSM #1, the social services director. OSM #1 was asked if she knew Resident #3's code status. OSM #1 stated

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Resident #3 was a full code. OSM #1 was asked if she was aware the electronic system stated Resident #3 was a DNR. OSM #1 stated she had learned of it the evening before and Resident #3 signed his DNR last night (on 8/29/17). At this time OSM #1 produced the Durable Do Not Resuscitate (DDNR) document that was observed in Resident #3's clinical record and the box documenting; "1. The patient is CAPABLE of making an informed decision about providing, withholding or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required.)" The document was signed by Resident #3 and the date 8/29/17 was written beneath the signature. There was no evidence of a new physician / nurse practitioner signature. When asked where the original, unsigned DDNR document that came with Resident #3's admission package was located, as it was no longer in the clinical record. OSM #1 stated it had been destroyed. OSM #1 stated, "On admission the document was accepted by nursing and the order was put in as a DNR, but it was not a valid document because it had not been signed." OSM #1 was asked when she was made aware that the DDNR document entered was not valid. OSM #1 stated that she was made aware of the document a few days after admission but she gave it to the admissions director (OSM #5) to follow up with Resident #3. When asked who followed up with Resident #3's code status, OSM #1 stated, "I went on vacation, I will have to ask my assistant." OSM #1 was asked if she was aware the computer system documented that Resident #3 was a DNR (d not resuscitate). OSM #1 stated she was not aware and as far as she knew he was a full code. OSM #1 was asked if Resident #3's code status was clear. OSM #1 stated that it was not.

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On 8/30/17 at 10:56 an interview was conducted with ASM #2, the director of nursing. ASM #2 was asked if she was aware Resident #3's original DDNR form that was with his admission package had be destroyed and the social services director (OSM #5) had Resident #3 sign a DDNR form dated 7/8/17. ASM #2 stated that the administrative team had divided tasks the night before and (name of OSM #1, the social services director) was addressing the code status of Resident #3. ASM #2 was asked whether or not it was appropriate for Resident #3 to be given an old DDNR document to sign. ASM #2 stated, "We should have addressed the DNR when he was admitted. There should have been a new DDNR document and the physician / nurse practitioner should have been asked to meet with the resident, along with Resident #3's sister/niece." ASM #2 stated that she was unaware the code status of Resident #3 was different on the clinical record and the comprehensive care plan.

On 8/30/17 at 12:04 p.m. an interview was conducted with OSM #5, the admissions director. OSM #5 was asked if she was responsible for ensuring residents had an advance directive in place. OSM #5 stated she would review the DNR and if they didn't have a DNR she would do the verification of full code. OSM #5 was asked what she did for Resident #3 at the time of readmission to the facility regarding his code status. OSM #5 stated she remembered doing a face to face with Resident #3 and he was a full code when he came into the facility. OSM #5 stated the DDNR form copied into Resident #3's clinical record was not in his original admission package. OSM #5 was asked if the social services director ever

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| F 155 | Continued From page 7<br>came to her with an incomplete DDNR form for Resident #3 so that she could verify the code status. OSM #5 stated she (the social services director, OSM #1) did not. OSM #5 further stated, "As far as I was concerned he (Resident #3) was a full code."<br><br>A review of the facility policy titled CPR (cardiopulmonary resuscitation) revealed, in part, the following documentation; "C) If a resident is found unresponsive and without a pulse, a staff member certified in CPR will initiate CPR unless: 1. It is known that a Do No (sic) Resuscitate (DNR) order that specifically prohibits CPR and / or external defibrillation exists for that individual."<br><br>A meeting was conducted on 8/30/17 at 1:30 p.m. with ASM #1, the administrator, ASM #2, the director of nursing. Both ASM #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern.<br><br>No further information was provided prior to the end of the survey process. | F 155 | | |
| F 157 SS=D | 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>(g)(14) Notification of Changes.<br><br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br><br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; | F 157 | | |

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| F 157 | Continued From page 8<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br><br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br><br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br><br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br><br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br><br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br><br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br><br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review and clinical record review, it was determined the | F 157 | F157 – Notify of changes (injury/decline/room,etc.)<br><br>1. Resident #4's MD was notified of medication not being administered as ordered. Resident #4 was assessed for signs/symptoms of scabies.<br>2. Any resident with medication orders, change Of condition have the potential to be affected By this deficient practice.<br>3. Licensed nurses educated on medication Not available policy and MD notification by DON/designee.<br>4. MD orders will be reviewed 5 times a week For 12 weeks by unit managers/designee for Medication availability and MD notification as needed. Results of audits will be taken to QAPI for Review and revisions as needed.<br>5. 10/4/2017 | |

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facility staff failed to notify the physician when a prescribed medication was not available at the time of administration for one of 19 residents in the survey sample, Resident #4.

The facility staff failed to notify the physician when a prescribed cream to treat scabies was unavailable at the prescribed administration time for Resident #4.

The findings include:

Review of the physician orders dated 8/15/17, documented, "Elimite Cream (Permethrin) 5%; Apply to (sic) from neck to ankles topically one time only for scabies." A second order dated 8/22/17 documented, "Elimite Cream 5%; Apply to (sic) from neck to ankles topically one time only for Scabies; Repeat in one week from first treatment."

ELIMITE (Trademark) (permethrin) 5% Cream is indicated for the treatment of infestation with Sarcoptesscabiei (scabies). (1)

Scabies is a contagious disease caused by the itch mite characterized by itching and skin irritation, often leading to secondary infection. (2)

Resident #4's MAR (medication administration record) for August 2017 documented, "Elimite Cream 5%; Apply to (sic) from neck to ankles topically one time only for Scabies; Repeat in one week from first treatment." Documented under the date of 8/22/17 was a "16." At the bottom of the MAR documentation revealed, "16" indicates, "Hold/See nurse's notes."

Review of the nurse's note for 8/22/17 at 7:16

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p.m. documented, "Cream not available." There were no further nurse's notes for this date.

Review of the comprehensive care plan dated 1/10/17, with a reviewed on 7/17/17 date did not reveal any documentation related to the exposure to scabies and treatment.

An interview was conducted with LPN (licensed practical nurse) #6 on 8/30/17 at approximately 9:37 a.m. When asked what staff should do when a medication is not available at the time of administration, LPN #6 stated, "If we don't have it in the cart, we check the STAT (immediate) box. If it's not there we call the pharmacy to get it (medication) delivered. We notify the physician and follow their orders to either hold it or give another medication in its place."

An interview was conducted with LPN #2, the unit manager, on 8/30/17 at 9:55 a.m., regarding how many treatments a resident receives for scabies. LPN #2 stated, "Two, one week apart." The treatment cart was observed with LPN #2. A full, unopened box/tube of Permethrin Cream 5% was found in the cart. Resident #4's MAR for August 2017 was shown to LPN #2. When asked what staff should do if a medication is not available at the prescribed time for administration, LPN #2 stated, "They could have gotten an order to give it the next day. They have to let the family know and the doctor know. They should have called me; I'm available 24 hours a day."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 8/30/17 at 10:07 a.m. When asked what process staff should follow when a medication is not available at the time of

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administration, ASM #2 stated, "First they should look in the STAT box. If (medication is) not there, then they should call the backup pharmacy. If (medication is) not available, the nurse should call the nurse practitioner or physician to see if there is an alternate and follow the doctor's instructions." The unopened box of Elimite cream and Resident #4's MAR and nurse's notes were shared with ASM #2.

The facility policy, "Medication Shortages/Unavailable Medications" documented in part, "4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions."

In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient.

The administrator and ASM #2 were made aware of the above concern on 8/30/17 at 1:30 p.m.

No further information was obtained prior to exit.

(1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cf

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| F 157 | Continued From page 12<br>m?setid=c6c509bb-658e-46eb-a844-8323ecd115de<br>(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader 5th edition, Rothenberg and Chapman; page 520. | F 157 | | |
| F 226 SS=D | 483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>483.12<br>(b) The facility must develop and implement written policies and procedures that:<br><br>(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>(2) Establish policies and procedures to investigate any such allegations, and<br><br>(3) Include training as required at paragraph §483.95,<br><br>483.95<br>(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-<br><br>(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.<br><br>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property | F 226 | F226 – Develop/implement abuse/neglect, etc. policies<br><br>1. Record #5's license was verified as current and Placed in her personnel file.<br>2. All residents have the potential to be affected By this deficient practice. 100% audit of current employees' licenses was Completed for current licenses and any areas Corrected as needed.<br>3. Human resources and Dept Managers were educated On employment license screening and annual license review By administrator/designee.<br>4. Audit of new employee personnel files 5 times a week By administrator/designee for 12 weeks for license verificatic An audit of current licensed staff monthly for 3 months By administrator/designee for current license. Results of audits will be taken to QAPI monthly for 3 months for review and revision as needed..<br>5. 10/4/2017 | |

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| F 226 | Continued From page 13<br>(c)(3) Dementia management and resident abuse prevention.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review and employee record review, it was determined that the facility staff failed to follow their policy and procedures for pre-employment screening for one of five employee records, Employee Record Review #5.<br><br>The facility staff failed to verify the license for Employee Record Review #5, a registered nurse.<br><br>The findings include:<br><br>Five employee records were reviewed for pre-employment screening. One of the five records, Employee Record Review #5, a registered nurse, did not contain a completed license verification.<br><br>An interview was conducted with other staff member (OSM) #6, the payroll/accounts payable staff member, on 8/30/17 at 8:47 a.m. When asked where the nursing license verification was located for Employee record review #5, OSM #6 stated, "They are with the ADON (assistant director of nursing)." OSM #6 left to find the missing document.<br><br>OSM #6 returned to this surveyor on 8/30/17 at 12:15 p.m. She stated, "I reran her license today." OSM #6 stated she still wanted to check with nursing department to see if they had the license verifications.<br><br>OSM #6 returned to this surveyor on 8/30/17 at 3:10 p.m. and stated, "I didn't have good luck with | F 226 | | |

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| F 226 | Continued From page 14<br>nursing. They didn't have the license verification either."<br><br>The facility policy, "Virginia Resident Abuse Policy" documented in part, "Procedure: 1. Screening - facility will not employ or otherwise engage individuals who have been found guilty of abuse, neglect, or mistreatment of residents by a court of law, had a finding of abuse, neglect, mistreatment, exploitation, involuntary seclusion and/or misappropriation of property reported into a state nurse aide registry, or had a disciplinary action taken against a professional license by a state licensure body as a results of a finding of abuse, neglect or mistreatment of residents or a finding of misappropriation of property. It is the policy of the Facility to undertake background checks to all employees and to retain on file applicable records of current employees regarding such checks. a. The facility will do the following prior to hiring a new employee: iii. Check with all applicable licensing and certification authorities to ensure that employees hold the requisite license and/or certification status to perform their job functions and have no disciplinary action as a result of abuse or neglect."<br><br>The administrator was made aware of the above concern on 8/30/17 at 1:30 p.m.<br><br>No further information was obtained prior to exit. | F 226 | | |
| F 250 SS=D | 483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE<br><br>(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial | F 250 | | |

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| F 250 | Continued From page 15<br>well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide medically necessary social services for one of 19 residents in the survey sample, Resident #3.<br><br>The social worker at the facility failed to clarify Resident #3's code status when he was readmitted to the facility on 7/6/17. The hospital discharge documentation included a partially completed DNR (do not resuscitate) form, which was entered into the computerized clinical record, and the admission directives documented Resident #3 as a full code.<br><br>The findings include;<br><br>Resident #3 was admitted to the facility on 2/14/17, with a readmission on 7/6/17, with diagnoses that included, but were not limited to; dementia, dysphagia (difficulty with swallowing), diabetes, cardiac arrhythmia (abnormal heart beat), low blood pressure, neuropathy (damaged nerves that cause numbness and pain in the feet), enlarged prostate gland and cachexia (a wasting disease with weight loss and muscle atrophy).<br><br>Resident #3's most recent MDS (minimum data set) was a 30-day assessment with an ARD (assessment reference date) of 8/3/17. Resident #3 was coded as scoring a six out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating that the resident was severely impaired with cognition. | F 250 | | |

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Further review of Resident #3's clinical record revealed a significant change MDS, assessment, with an ARD of 7/13/17. Resident #3 was coded as scoring a three out of a possible 15 on the BIMS, indicating that the resident was severely impaired with cognition.

A review of Resident #3's Admission Notification Form completed by OSM (other staff member) #5, the admissions director revealed, in part, the following documentation: "Special Equipment /Needs/ Notes: FULL CODE! Responsible Party Name and Phone: Self."

A review of Resident #3's hospital history and physical dated 7/1/17 revealed, in part, the following documentation: "Code Status: Patient Code Status: Full Code."

A review of Resident #3's Admission Record (face sheet) revealed, in part, the following documentation; "Advance Directive: DNR."

A review of Resident #3's admission assessment dated 7/6/2017 at 18:26 (6:26 p.m.) revealed, in part, the following documentation; "Code Status: DNRCC (do not resuscitate comfort care). Advanced Directives were explained. Oriented to Person, Place."

A review of Resident #3's clinical record revealed, in part, the following physician order signed by ASM (administrative staff member) #4, the nurse practitioner, on 7/10/17; "7/6/2017 18:29 (6:29p.m.) Communication method: Verbal. Order Summary: DNR (do not resuscitate)."

Further review of Resident #3's clinical record

F250 – Provision of medically related social service

1. Resident #3's advanced directive was Reviewed with resident, MD and RP and clarification placed in clinical record care plan updated.
2. All residents have the potential to be affected by this deficient practice. 100% audit of current residents' code status completed.
3. Social service dept and licensed nurses nursing educated on ensuring code status accuracy by administrator/designee..
4. An audit of new admissions/readmissions will be conducted 5 times a week by Unit managers/designee for accurate code status. Current residents will have code status reviewed with significant change, quarterly and annual MDS by social services for any code status change. Audits will be completed for 12 weeks. Results of audits will be taken to QAPI monthly for 3 months for review and revision as needed.
5. 10/4/2017

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revealed a Durable Do Not Resuscitate Order document dated 7/8/2017 that contained Resident #3's full name. The DDNR document was not completed to determine Resident #3's wishes; the document was signed by a physician from the hospital and there was no signature by Resident #3 or a responsible party.

A review of Resident #3's comprehensive care plan dated 7/6/17 revealed, the following documentation; "Focus: Code Status: Resident / Responsible party has chosen Full Code. Date Initiated: 7/7/2017. Goal: Resident's / Responsible party code status wish will be honored daily through next review. Date Initiated: 7/7/2017. Interventions: Notify physician of any changes. Date Initiated: 7/7/2017."

A review of the social service progress notes revealed, in part, the following documentation; "Social Services; 7/7/17. Resident has stay under Medicare. He is a full code. Social Services; 7/12/17. Resident has stay under Medicaid. He is a full code. Resident with support of sister. Resident with confusion to time. He has HX (history) of dementia. He has short term memory loss. 8/29/17 Created by: (name of OSM [other staff member] #1, social services director). Resident is his own RP (responsible party). Resident signed his DNR form this day. Change made to care plan."

On 8/29/17 at 4:50 p.m. an interview was conducted with LPN (licensed practical nurse) #10, a floor nurse taking care of Resident #3. LPN #10 was asked what Resident #3's code status was. LPN #10 reviewed Resident #3's clinical record via the computer software program, Point Click Care, and stated, "He

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(Resident #3) is DNR." When asked if that was the quickest way to determine the code status of a resident, LPN #10 stated, "We just look in the computer but we also have a book at the nurses' station that indicates the code status on their face sheets."

This surveyor reviewed the book referred to by LPN #10 and there were no face sheets for Resident #3 in the book.

On 8/29/17 at 5:45 p.m. an end of day meeting was held with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #2 was asked to describe the process followed when residents change from being a full code to a DNR. ASM #2 stated, "The nurse practitioner or physician meet with the resident and/ or the responsible party to discuss the change requested. Both the resident/responsible party and the physician / nurse practitioner would sign the form, the information would be updated electronically into the computer system (point click care) and the care plan would be updated." ASM #1 and ASM #2 were made aware that Resident #3's care plan and admission documentation state that Resident #3 is a full code and the electronic information the nursing staff refer to documents that Resident #3 is a DNR.

On 8/30/17 at 10:00 a.m. an interview was conducted with OSM #1, the social services director. OSM #1 was asked if she knew Resident #3's code status. OSM #1 stated Resident #3 was a full code. OSM #1 was asked if she was aware the electronic system stated Resident #3 was a DNR. OSM #1 stated she had learned of it the evening before and Resident #3

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signed his DNR last night (on 8/29/17). At this time OSM #1 produced the Durable Do Not Resuscitate (DDNR) document that was observed in Resident #3's clinical record and the box documenting; "1. The patient is CAPABLE of making an informed decision about providing, withholding or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required.)" The document was signed by Resident #3 and the date 8/29/17 was written beneath the signature. There was no evidence of a new physician / nurse practitioner signature. When asked where the original, unsigned DDNR document that came with Resident #3's admission package was located, as it was no longer in the clinical record. OSM #1 stated it had been destroyed. OSM #1 stated, "On admission the document was accepted by nursing and the order was put in as a DNR, but it was not a valid document because it had not been signed." OSM #1 was asked when she was made aware that the DDNR document entered was not valid. OSM #1 stated that she was made aware of the document a few days after admission but she gave it to the admissions director (OSM #5) to follow up with Resident #3. When asked who followed up with Resident #3's code status, OSM #1 stated, "I went on vacation, I will have to ask my assistant." OSM #1 was asked if she was aware the computer system documented that Resident #3 was a DNR (d not resuscitate). OSM #1 stated she was not aware and as far as she knew he was a full code. OSM #1 was asked if Resident #3's code status was clear. OSM #1 stated that it was not.

On 8/30/17 at 11:35 a.m. a private meeting was held with Resident #3 in his room. Resident #3 was asked if he remembered having a

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conversation the evening before with the social services director about his code status. Resident #3 did not understand the term "code status" and it was explained. Resident #3 stated that he did remember the social services director speaking with him and that he wanted them (the staff) to do that. Resident #3 did not provide any further information.

On 8/30/17 at 11:40 a.m. a meeting was held with OSM #1, the social worker. OSM #1 was asked if Resident #3 was competent to be his own responsible party. OSM #1 stated that she did not determine competency, the physician had to do that. OSM #1 further stated the admissions director (OSM #5) determined if residents could act as their own RP prior to admission. OSM #1 was asked at what point she would question a resident's ability to make decisions / act as their own responsible party. OSM #1 stated, "If there was a medical decline, or a change on the BIMS assessments." When asked if Resident #3 was sufficiently cognitive to understand the DDNR form presented to him for a signature on 8/29/17, OSM #1 stated that she thought so. OSM #1 stated, "I explained everything very clearly and he stated that he didn't want to live like this any longer." When asked if the physician or nurse practitioner had been involved in the conversation, OSM #1 stated they had not. OSM #1 was asked if the document she had Resident #3 sign on 8/29/17 was valid, OSM #1 did not answer.

On 8/30/17 at 10:56 an interview was conducted with ASM #2, the director of nursing. ASM #2 was asked if she was aware Resident #3's original DDNR form that was with his admission package had be destroyed and the social

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services director (OSM #5) had Resident #3 sign a DDNR form dated 7/8/17. ASM #2 stated that the administrative team had divided tasks the night before and (name of OSM #1, the social services director) was addressing the code status of Resident #3. ASM #2 was asked whether or not it was appropriate for Resident #3 to be given an old DDNR document to sign. ASM #2 stated, "We should have addressed the DNR when he was admitted. There should have been a new DDNR document and the physician / nurse practitioner should have been asked to meet with the resident, along with Resident #3's sister/niece." ASM #2 stated that she was unaware the code status of Resident #3 was different on the clinical record and the comprehensive care plan.

On 8/30/17 at 12:04 p.m. an interview was conducted with OSM #5, the admissions director. OSM #5 was asked if she was responsible for ensuring residents had an advance directive in place. OSM #5 stated she would review the DNR and if they didn't have a DNR she would do the verification of full code. OSM #5 was asked what she did for Resident #3 at the time of readmission to the facility regarding his code status. OSM #5 stated she remembered doing a face to face with Resident #3 and he was a full code when he came into the facility. OSM #5 stated the DDNR form copied into Resident #3's clinical record was not in his original admission package. OSM #5 was asked if the social services director ever came to her with an incomplete DDNR form for Resident #3 so that she could verify the code status. OSM #5 stated she (the social services director, OSM #1) did not. OSM #5 further stated, "As far as I was concerned he (Resident #3) was a full code." When asked if Resident #3

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| F 250 | Continued From page 22<br>was competent and able to make an informed decision in regards to his code status, OSM #5 stated he (Resident #3) is alert and oriented but that there was a change in cognition at the time of his readmission.<br><br>On 8/30/17 at 2:40 p.m. an interview was conducted with ASM #4, the nurse practitioner. ASM #4 was asked if she would expect the staff to talk to her about his cognitive status.<br><br>A review of the facility policy titled CPR (cardiopulmonary resuscitation) revealed, in part, the following documentation; "C) If a resident is found unresponsive and without a pulse, a staff member certified in CPR will initiate CPR unless: 1. It is known that a Do No (sic) Resuscitate (DNR) order that specifically prohibits CPR and / or external defibrillation exists for that individual."<br><br>A review of the facility policy titled Social Services, revealed, in part the following documentation; "B) Social Services will assist in implementing interventions for the resident's needs by developing and maintaining care plans which are individualized, realistic with measurable goals, including but not limited to; 1) Code Status. "<br><br>A meeting was conducted on 8/30/17 at 1:30 p.m. with ASM #1, the administrator, ASM #2, the director of nursing. Both ASM #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern.<br><br>No further information was provided prior to the end of the survey process. | F 250 | | |
| F 278 | 483.20(g)-(j) ASSESSMENT | F 278 | | |

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| F 278 SS=D | Continued From page 23<br>ACCURACY/COORDINATION/CERTIFIED<br><br>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.<br><br>(h) Coordination<br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>(i) Certification<br>(1) A registered nurse must sign and certify that the assessment is completed.<br><br>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>(j) Penalty for Falsification<br>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(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<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review and clinical record review, it was determined that | F 278 | F278 – Assessment accuracy/coordination/certified<br><br>1. Resident #2's MDS was corrected and submitted To CMS.<br>2. Any resident requiring an MDS has the potential To be affected by this deficient practice.<br>3. MDS department and IDCP team educated on accurate Completion of MDS by Regional Reimbursement Specialist.<br>4. Audit of 5 MDSs weekly prior to submission for 12 weeks by DON/designee for accuracy and completeness. Results will Be taken to QAPI monthly for 3 months for review and revisic As needed.<br>5. 10/04/17 | |

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the facility staff failed to ensure a complete and accurate MDS (minimum data set) assessment for one of 19 residents in the survey sample, Resident #2.

The facility staff coded Resident #2 as having received antidepressant medication and antibiotic medication which the resident did not receive.

The findings include:

Resident #2 was admitted to the facility on 3/6/17 with diagnoses, that included, but were not limited to: emphysema (abnormal condition of the lungs in which there is over inflation of the air sacs of the lungs, leading to a breakdown of their walls, and a decrease in respiratory function (1)), edema, history of breast cancer, dementia, and gastroesophageal reflux disease (backflow of the contents of the stomach into the esophagus (2)).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/4/17, coded the resident as scoring a six on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make cognitive daily decisions. The resident was coded as requiring supervision to limited assistance for all of her activities of daily living. In Section N - Medications, the resident was coded as having received seven days of an anti-depressant medication and four days of an antibiotic medication.

Review of the clinical record failed to evidence any physician orders or documentation evidencing that Resident #2 received any antibiotics or anti-depressants during the

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seven-day look back period.

An interview was conducted with LPN (licensed practical nurse) #4 and LPN #3, both MDS coordinators, on 8/30/17 at 9:16 a.m. LPN #3 stated, "I have not had an assistant in MDS in several months. They (the facility) brought in nurses from other facilities to help me during this time. One of them completed the MDS." LPN #3 and LPN #4 reviewed Resident #2's MARs (medication administration records) for July and August 2017. When asked if they saw any documentation of antibiotics or antidepressants given during the lookback period, LPN #3 stated, "If there is no documentation, we will file a modification."

On 8/30/17 at 12:40 p.m. LPN #3 handed this surveyor a MDS modification report for Section N - Medications for Resident #2's quarterly assessment, with an assessment reference date of 8/4/17.

The administrator, ASM (administrative staff member) #1 and ASM #2, the director of nursing were made aware of the above findings on 8/30/17 at 1:30 p.m.

The facility provided a copy of the RAI (resident assessment instrument) manual (October 2016) for Section N - Medications, on 8/30/17 at approximately 1:30 p.m.
Steps for Assessment
Review the resident's medical record for documentation that any of these medications were received by the resident during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
N0410C, Antidepressant: Record the number of

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| F 278 | Continued From page 26<br>days an antidepressant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).<br>N0410F, Antibiotic: Record the number of days an antibiotic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).<br><br>No further information was provided prior to exit.<br><br>(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 190.<br>(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 243. | F 278 | | |
| F 279 SS=D | 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>483.20<br>(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.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(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 | F 279 | | |

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includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

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

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

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

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

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

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

(C) Discharge plans in the comprehensive care

F279 – Develop Comprehensive Care Plan

1. Resident #7's care plan was reviewed and is current to include vision and communication.
2. Any resident requiring a comprehensive care plan Has the potential to be affected by this deficient Practice.
   100% audit of comprehensive care plans developed in last 30 days reviewed for accuracy.
3. MDS and the IDCP team educated on generating Comprehensive care plans from MDS by Regional Reimbursement Specialist.
4. Audit of 5 comprehensive care plans weekly prior to MDS submission for 12weeks for accuracy by DON/designee. Results of audits to QAPI monthly for 3 months for review And revision as needed.
5. 10/04/17

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plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to develop a comprehensive care plan to address the triggered care areas identified on the CAAs (care area assessments) section of the MDS (minimum data set) assessment for one of 19 residents in the survey sample, Resident #7.

The facility staff failed to develop a comprehensive care plan for the triggered care area of vision and communication on Resident #7's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 6/2/17.

The findings include;

Resident #7 was admitted to the facility on 5/27/17 with diagnoses that included, but were not limited to; low red blood cell count, high blood pressure, diabetes, arthritis, pain, cardiovascular disease and encephalopathy (swelling of the brain).

Resident #7's most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/2/17 revealed, in part, that Resident #7 scored a 12 out of a possible 15 on his BIMS (brief interview of mental status), indicating that Resident #7 was cognitively moderately impaired to make daily decisions.

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Further review of Resident #7's MDS admission assessment with an ARD of 6/2/17 revealed in Section V - Care Area Assessment (CAA) that "03. Vision and 04. Communication" were checked as triggered care areas under column "A" and also checked under column "B. Care Planning Decision." The instruction provided in Section V states, "2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. Check column B if the triggered care area is addressed in the care plan."

A review of Resident #7's comprehensive care plan dated 5/25/17 did not reveal any documentation regarding vision or communication.

On 8/30/17 at approximately 9:20 a.m. an interview was conducted with LPN (licensed practical nurse) #3, the MDS coordinator. LPN #3 was asked who developed the care plans from the CAA triggered areas. LPN #3 stated that she would be responsible for that. LPN #3 was asked to review Resident #7's care plan specifically for vision and communication. LPN #3 reviewed Resident #7's care plan and stated that vision and communication were not care planned and she could not state why.

On 8/30/17 at 1:30 p.m. a meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. At this time ASM #1 and ASM #2 were made aware of the above concern. A policy regarding the development of a care plan was requested.

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| F 279 | Continued From page 30<br><br>The facility staff provided this surveyor with the section regarding care area assessments and care planning from the RAI (resident assessment instrument) manual. LPN #3 was asked if they used the RAI manual for all care planning and MDS completions, LPN #3 stated that they did.<br><br>No further information was provided prior to the end of the survey process. | F 279 | | |
| F 280 SS=D | 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>483.10<br>(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:<br><br>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.<br><br>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.<br><br>(iv) The right to receive the services and/or items included in the plan of care.<br><br>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.<br><br>(c)(3) The facility shall inform the resident of the | F 280 | F280 – Right to participate planning care-revise CP<br>1. Residents #4, #14, #1 care plans were reviewed and Updated as needed.<br>2. Any resident with care plan has the potential to be Affected by this deficient practice. Audit of MD orders for last 30 days relating to resident change of condition with care plan review for accuracy.<br>3. MDS, IDCP team, licensed nurses educated on review and updating Care plan for change of condition by DON/designee..<br>4. Review of 10 care plans a week for 12 weeks MDS nurse/designee for accuracy. Results of audit will be taken to QAPI monthly for 3 months for review and revisions as needed.<br>5. 10/4/2017 | |

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right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident

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and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, resident interview, facility document review and clinical record review, it was determined that the facility staff failed to review and revise the care plans for three of 19 residents in the survey sample, Residents #4, #14 and #1.

1. The facility staff failed to review and revise Resident #4's comprehensive care plan to reflect the exposure and treatment of scabies.

2. The facility staff failed to review and revise Resident #14's comprehensive care plan after a readmission to reflect the use and care of an indwelling catheter and recent transfer to the hospital for a GI (gastrointestinal) bleed.

3. The facility staff failed to review and revise Resident #1's comprehensive care plan to address Resident #1's preference to keep her bed at a high elevation so that she could look out of the window.

The findings include:

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1. The facility staff failed to review and revise Resident #4's comprehensive care plan to reflect the exposure and treatment of scabies.

Resident #4 was admitted to the facility on 1/9/17 with diagnoses that included, but were not limited to: stroke, diabetes, depression, insomnia, and dementia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/23/17, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating that she was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance for all of her activities of daily living except eating in which she was coded as requiring supervision after set up assistance was provided.

Review of the physician orders dated 8/15/17, documented, "Elimite Cream (Permethrin) 5%; Apply to (sic) from neck to ankles topically one time only for scabies." A second order dated 8/22/17 documented, "Elimite Cream 5%; Apply to (sic) from neck to ankles topically one time only for Scabies; Repeat in one week from first treatment."

ELIMITE (Trademark) (permethrin) 5% Cream is indicated for the treatment of infestation with Sarcoptesscabiei (scabies). (1)

Scabies is a contagious disease cause by the itch mite and characterized by itching and skin irritation, often leading to secondary infection. (2)

The nurse's notes failed to evidence any

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documentation related to the scabies exposure.

Review of the comprehensive care plan dated 1/10/17 and reviewed on 7/17/17 did not reveal any documentation related to the exposure or treatment of scabies.

An interview was conducted with LPN (licensed practical nurse) #3 and LPN #4, both MDS nurses, on 8/30/17 at 9:16 a.m. When asked who updates the care plans, LPN #3 stated, "Everyone, the whole disciplinary team; dietary, activities, social services, all of nursing, and unit managers. When asked who uses the care plan, LPN #4 stated, "Everyone."

An interview was conducted with LPN (licensed practical nurse) #4 on 8/30/17 at 10:32 a.m. When asked if a resident is exposed to scabies and is receiving treatment, should this be included on the care plan, LPN #4 stated, "Yes, because we are going to monitor the person." LPN #4 reviewed Resident #4's care plan in the computer. When asked if she saw exposure to and treatment of scabies on the care plan, LPN #4 stated, "It's not there."

An interview was conducted with ASM (administrative staff member) #3, the assistant director of nursing, on 8/30/17 at 11:28 a.m. When asked who updates the care plans, ASM #3 stated, "Anyone of us, MDS, unit managers, myself, DON (director of nursing) and other departments." When asked if a resident is treated prophylactically for scabies should the treatment be on the care plan, ASM #3 stated, Yes."

The facility policy, "Care Plan" documented in part, "The MDS Coordinator is to review the 24 -

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Hour Report daily for significant changes or changes in resident's ADL (activities of daily living) status. The Care Planning coordinator will add minor changes in resident's status to the existing Care Plans on a daily basis."

The administrator and director of nursing were made aware of the above findings on 8/30/17 at 1:30 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c6c509bb-658e-46eb-a844-8323ecd115de.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, Rothenberg and Chapman; page 520.

2. The facility staff failed to review and revise Resident #14's comprehensive care plan after a readmission to reflect the use and care of an indwelling catheter and recent transfer to the hospital for a GI (gastrointestinal) bleed.

Resident #14 was admitted to the facility on 7/25/17 with a readmission on 8/26/17 with diagnoses that included, but were not limited to: acute urinary retention, lower GI bleed, atrial fibrillation (condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequent clot formation (1)), high blood pressure, diabetes, and benign prostatic hypertrophy (is a condition in men in which the prostate gland is enlarged and not cancerous. Benign prostatic hyperplasia is

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also called benign prostatic hypertrophy or benign prostatic obstruction (2)).

The most recent MDS (minimum data set) assessment, a Medicare 14-day assessment, with an assessment reference date of 8/8/17, coded Resident #14 as scoring a 15 on the BIMS (brief interview for mental status) score, indicating he was cognitively intact to make daily decisions. Resident #14 was coded as requiring extensive assistance of one staff member for most of his activities of daily living except eating in which he was coded as requiring supervision with one-person physical assist. Section H - Bladder and Bowel coded the resident as being frequently incontinent of both urine and bowel.

Review of the clinical record revealed documentation of Resident #14 leaving the facility on 8/21/17 due to blood coming from the rectum. He was transferred to the hospital.

The discharge summary from the hospital dated, 8/26/17, documented in part, "HX (history) (Resident #14) is an 86 year old male past medical history significant for diabetes, hypertension (high blood pressure), atrial fibrillation. On Eliquis (ELIQUIS® [apixaban] is indicated to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation (3)), presented from (name of facility) with rectal bleeding that was noted the morning of admission. Patient had been complaining of sharp intermittent rectal pain for about 2 days. He had been constipated was started on Miriax (sic) (Miralax - used to treat constipation (4)). He has some nausea but no vomiting. No urinary symptoms of frequency or dysuria, patient does use the urinal but he does

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report some urinary straining and dribbling.... CT (computerized tomography) scan showed: Extremely distended bladder suggesting a bladder outlet obstruction and likely due to an enlarged prostate...Patient was admitted for evaluation of lower rectal bleeding and urinary retention."

The nursing admission note dated, 8/26/17 at 7:13 p.m., documented, "Patient was admitted from (name of hospital) via ambulance, patient arrived at 14:20 p.m. (2:20 p.m.), family was present. Patient is alert and oriented times 4. (Person, place, time, situation). Patient arrived with Foley (indwelling catheter) from hospital."

The physician orders dated, 8/26/17, documented in part the following:
Anchor catheter tubing and check placement every shift.
Change catheter PRN (as needed)
Maintain Catheter drainage bag below bladder level every shift
Provide catheter Care as needed
Provide catheter care every evening shift
Provide Privacy cover for Drainage bag every shift.
Record Foley output every shift for monitoring.

On 8/30/17, review of the comprehensive care plan dated 7/28/17, with a revised on date of 8/6/17, was conducted, and failed to evidence any documentation of the indwelling catheter.

Further review of the comprehensive care plan dated, 8/6/17, with a revised on date of 8/17/17, documented in part, "Focus: At risk for constipation r/t decrease mobility, medications." The "Interventions" documented in part,

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"Administer medications as ordered. Consult dietary for assistance in meeting dietary needs. Monitor for constipation and causes. Further review of the care plan did not reveal any documentation related to Resident #14 having constipation and a lower GI bleed.

An interview was conducted with LPN (licensed practical nurse) #5 on 8/30/17 at 4:27 p.m. When asked who is responsible for updating the care plan, when a resident has a readmission to the facility, and there is a change in the care needs of the resident, LPN #5 stated, "The floor nurse or admitting nurse and it is verified by the MDS nurse." When asked how soon after a readmission should the care plan be updated with new care needs, LPN #5 stated, "I believe in the first 24 hours."

An interview was conducted with LPN #1, the unit manager, on 8/30/17 at 4:29 p.m. When asked who is responsible for updating the care plan, when a resident has a readmission to the facility, and there is a change in the care needs of the resident, LPN #1 stated, "The MDS nurses." When asked how soon after a readmission should the care plan be updated with new care needs, LPN #1 stated, "I think it's 48 hours per (corporate name) policy."

An interview was conducted with the MDS nurses, LPN #3 and LPN #4, on 8/30/17 at 4:32 p.m. When asked who is responsible for updating the care plan, when a resident has a readmission to the facility, and there is a change in the care needs of the resident, LPN #3 stated, "All departments update their section." When asked how soon it should be updated, LPN #3 stated, "As soon as things are identified." When asked

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who uses the care plan, LPN #4 stated, "Everyone who provides care for the resident."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 8/30/17 at approximately 5:00 p.m. When asked who is responsible for updating the care plan, when a resident has a readmission to the facility, and there is a change in the care needs of the resident, ASM #2 stated, "The unit manager and the admission nurse should do it. I've been helping out with that myself. We have only had one MDS nurse for the past two months. I have asked, (LPN #1) and (LPN #2) the unit managers to help with this process." When asked how soon the care plan to be updated, especially with a change in care needs, ASM #2 stated, "As soon as possible, first eight to sixteen hours but no more than 24 hours." Resident #14's care plan was reviewed with ASM #2 for his indwelling catheter and his history of lower GI bleed. When asked if the history of GI bleed and indwelling foley catheter should be on the care plan, ASM #2 stated, "Yes, it should have been updated."

The administrator was made aware of the above concern on 8/30/17 at 5:40 p.m.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, Rothenberg and Chapman; page 55.
(2) This information was obtained from the following website: https://www.niddk.nih.gov/health-information/urologic-diseases/prostate-problems/prostate-enlargement-benign-prostatic-hyperplasia.
(3) This information was obtained from the following website:

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https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=e9481622-7cc6-418a-acb6-c5450daae9b0
(4) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d69ce3d4-7ca4-4fe3-b49e-6655e48d6963

3. The facility staff failed to review and revise Resident #1's comprehensive care plan to address Resident #1's preference to keep her bed at a high elevation so that she could look out of the window.

Resident #1 was admitted to the facility on 6/27/17 with diagnoses that included, but were not limited to, pressure ulcers, pain, high blood pressure, high lipid levels in the blood stream, respiratory failure and peripheral vascular disease.

Resident #1's most recent comprehensive MDS (minimum data set) was an admission assessment with an ARD (Assessment reference date) of 7/5/17. Resident #1 scored an 11 out of a possible 15 on her BIMS (brief interview of mental status) indicating that she is cognitively moderately impaired with daily decision making. Resident #1 was also coded in Section V as having a CAA (care area assessment) trigger of falls.

A review of Resident #1's comprehensive care plan dated 6/28/2016 revealed, in part, the following documentation; "Focus: At high risk for falls/impaired safety r/t (related to) decline in function, pain management, Hx (history) of UTI (urinary tract infection), respiratory failure.

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7/21/17 Fall r/t resident being lowered to the floor without injury. Interventions: Fall matts (sic) at bedside to help prevent injuries in case of a fall. Date Initiated: 8/22/2017. Maintain safe environment. Date Initiated: 6/28/2017. Instruct on appropriate safety measures. Date initiated: 7/22/2017."

Resident #1 was observed on 8/28/17 at 3:15 p.m. in her room lying in her bed. Resident #1 stated that she had just had her pressure ulcer dressings changed and was resting. The bed was in a normal height position.

Resident #1 was observed on 8/29/17 at 4:20 p.m. in her room lying in her bed. The bed was observed at an elevated height. At this time CNA (certified nursing assistant) #1 was asked to come into Resident #1's room and to state what she saw in regards to the bed. CNA #1 stated, "The bed is high and it shouldn't be." When asked if this was a problem, CNA #1 stated that she (Resident #1) could get hurt if she fell out of the bed or tried to get up unassisted. When asked why the bed was so high, CNA #1 stated that she did not know.

At approximately 4:25 p.m. RN (registered nurse) #1 was asked to look in Resident #1's room. At this point CNA #1 had lowered Resident #1's bed and Resident #1 was still lying in the bed. RN #1 was asked what was considered a safe position for the bed; RN #1 stated that the bed should be at a height that the resident could safely get out of bed unassisted. RN #1 was asked if the bed was currently in a safe position at the lowered position of the bed. RN #1 stated that it was. When asked if the bed was in a position that was twice as high would that be considered safe, RN #1

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stated that it would not be safe at a higher position. RN #1 further stated, "We do make sure that the bed is lowered after we complete care but (name of Resident #1) raises her bed up to a higher level so it is easier to look out of the window." When asked this question Resident #1 verified that she preferred the bed higher. RN #1 was asked if Resident #1 was care planned to reflect the residents wishes and if the risks associated with keeping the bed at a higher level had been discussed with Resident #1; also if the aides been trained on providing Resident #1 with alternative options that may meet Resident #1's needs. RN #1 stated that she did not know. RN #1 was asked to review Resident #1's care plan with this writer. A review of Resident #1's care plan revealed there was no documentation regarding Resident #1's preference to keep her bed in high position.

On 8/30/17 at 9:30 a.m. an interview was conducted with LPN (licensed practical nurse) #3, MDS coordinator. LPN #3 was asked who was responsible for updating the care plans. LPN #3 stated that everyone in the IDT (interdisciplinary team) was responsible, nursing staff, dietary and social workers. When asked who used the care plan LPN #3 stated that everyone did.

On 8/30/17 at 1:15 p.m. an end of day meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above concern. When asked if Resident #1's care plan should have been reviewed and revised when it became clear to them that Resident #1 was putting her bed in a higher position. ASM #2 stated that it should have. A policy was requested related to the

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| F 280 | Continued From page 43<br>review and revision of care plans. This writer was provided with the section out of the RAI (resident assessment instrument) manual that provides guidance for the development, review and revision of care plans.<br><br>No further information was provided prior to the end of the survey process. | F 280 | | |
| F 281 SS=D | 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>(b)(3) Comprehensive Care Plans<br><br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of 19 residents in the survey sample, Resident #4.<br><br>The facility staff failed to transcribe the physician order for Estrace Cream correctly in the computer system, thus resulting in the resident not receiving this medicated cream since admission on 1/10/17.<br><br>The findings include:<br><br>Resident #4 was admitted to the facility on 1/9/17 with diagnoses that included, but were not limited to: stroke, diabetes, depression, insomnia, and dementia. | F 281 | F281 – Services provided meet professional standards<br><br>1. Resident #4's MD was notified of resident not receiving Medication. Resident #4's MD orders reviewed and current.<br>2. Any resident with physician orders has the potential to Be affected by this deficient practice.<br>3. Licensed nurses educated on transcribing physician orders by DON/designee.<br>4. Audit of physician orders 5 times a week for 12 weeks by UM/designee for accurate transcription. Results of Audits will be taken to QAPI monthly for 3 months for Review and revision as needed.<br>5. 10/4/2017 | |

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The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/23/17, coded Resident #4 as scoring a "13" on the BIMS (brief interview for mental status) score, indicating that she was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance for all of her activities of daily living except eating in which she was coded as requiring supervision after set up assistance was provided.

The physician orders dated, 1/12/17 documented, "Estrace Cream 0.1 MG/GM (milligram per gram); 1 gram vaginally every night shift every 7 days related to personal history of estrogen therapy - unsupervised self-administration. Start date 1/12/17."

ESTRACE (estradiol vaginal cream, USP, 0.01%) is indicated in the treatment of vulvar and vaginal atrophy. (1)

Review of Resident #4's January, February, March, April, May, June, July, and August 2017 MAR (medication administration record) revealed the following documentation: "Estrace Cream 0.1 MG/GM; 1 gram vaginally every night shift every 7 days related to personal history of estrogen therapy - unsupervised self-administration. Start date 1/12/17." Documented under the dates once a week, for all of the months since January, "U-SA."

Review of the comprehensive care plan dated, 1/10/17, did not reveal any documentation related to the use of Estrace Cream.

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| F 281 | Continued From page 45 | F 281 | | |

Review of the nurse's notes from 1/10/17 through 8/28/17, did not evidence anything related to the use or administration of the Estrace Cream.

An interview was conducted with LPN (licensed practical nurse) #4 on 8/30/17 at 9:30 a.m. LPN #4 was asked to review the MAR for Resident #4. When asked what "U-SA" means, LPN #4 stated that she would have to find out.

An interview was conducted with LPN #1, the unit manager, on 8/30/17 at 9:45 a.m. When shown Resident #4's MAR, and asked what "U-SA" means, LPN #1 stated, "It's unsupervised - self administration."

LPN #4 returned to this surveyor, and stated, that "U-SA means unsupervised - self administration." LPN #4 also stated, "The person who entered the order made a data entry error checking this (medication) to be self-administered."

An interview was conducted with LPN #7 on 8/30/17 at 9:55 a.m. When asked if any residents can self-administer medications, LPN #7 stated, "We don't have any resident that can self-administer medications on this unit (the unit on which Resident #4 resided)."

An interview was conducted with LPN #2, the unit manager of Resident #4's unit, on 8/30/17 at 9:55 a.m. When asked if residents can self-administer medications, LPN #2 stated, "No, we would need a physician's order to allow that." When asked to see the Estrace cream from the treatment cart, LPN #2 informed this surveyor that she had given the box and tube to the DON (director of nursing), ASM (administrative staff member) #2.

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| F 281 | Continued From page 46<br>An interview was conducted with the ASM #2 on 8/30/17 at 10:07 a.m. This surveyor asked to see Resident #4's boxes of Estrace Cream. One box from an outside pharmacy was open and had been used. The date on the prescription label was 1/5/17. The other box of cream was from the facility pharmacy and was dated 1/12/17. This tube of Estrace Cream was not open. The MARs from January through August were reviewed with the ASM #2. ASM #2 stated, "The nurse who transcribed the order was new to electronic records. She made a data entry error." When asked how it could have gone on since January, the DON could not answer.<br><br>The facility policy, "Physician Orders" documented in part, "The Charge Nurse shall transcribe all physician orders in order to affect their implementation....1. Transcribe all orders from the transfer form to the faculty admission physician order form. Order should include the following: ...b. medication, c. treatments."<br><br>The administrator and the director of nursing were made aware of the above findings on 8/30/17 at 1:30 p.m.<br><br>No further information was provided prior to exit.<br><br>(1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=7822. | F 281 | | |
| F 282 SS=D | 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, | F 282 | | |

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| F 282 | Continued From page 47<br>as outlined by the comprehensive care plan, must-<br><br>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, resident interview, facility document review and clinical record review, it was determined that the facility staff failed to follow the comprehensive care plan for one of 19 residents in the survey sample, Resident #1.<br><br>The facility staff failed to place fall mats beside Resident #1's bed when she was in the bed as directed in Resident #1's comprehensive care plan as a safety intervention.<br><br>The findings include;<br><br>Resident #1 was admitted to the facility on 6/27/17 with diagnoses that included, but were not limited to, pressure ulcers, pain, high blood pressure, high lipid levels in the blood stream, respiratory failure and peripheral vascular disease.<br><br>Resident #1's most recent comprehensive MDS (minimum data set) was an admission assessment with an ARD (Assessment reference date) of 7/5/17. Resident #1 scored an 11 out of a possible 15 on her BIMS (brief interview of mental status) indicating that she is cognitively moderately impaired with daily decision making. Resident #1 was also coded in Section V as having a CAA (care area assessment) trigger of falls. | F 282 | F282 – Services by qualified persons/per care plan<br>1. Resident #1's care plan was reviewed and is current.<br>2. Any resident requiring care plans has the potential To be affected by this deficient practice.<br>3. Nursing staff educated on utilization/following care plans by DON/designee.<br>4. An audit of 10 residents weekly for 12 weeks by MDS Nurse/designee for care plan interventions in place. Results of audits to QAPI monthly for 3 months for Review and revisions as needed.<br>5. 10/04/17 | |

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A review of Resident #1's comprehensive care plan dated 6/28/2016 revealed, in part, the following documentation; "Focus: At high risk for falls/impaired safety r/t (related to) decline in function, pain management, Hx (history) of UTI (urinary tract infection), respiratory failure. 7/21/17 Fall r/t resident being lowered to the floor without injury. Interventions: Fall matts (sic) at bedside to help prevent injuries in case of a fall. Date Initiated: 8/22/2017. Maintain safe environment. Date Initiated: 6/28/2017. Instruct on appropriate safety measures. Date initiated: 7/22/2017."

Resident #1 was observed on 8/28/17 at 3:15 p.m. in her room, lying in her bed. Resident #1 stated that she had just had her pressure ulcer dressings changed and was resting. There were no fall mats observed on the floor beside the bed.

Resident #1 was observed on 8/29/17 at 4:20 p.m. in her room lying in her bed. The bed was observed at an elevated height, and there were no fall mats on the floor beside the bed. At this time CNA (certified nursing assistant) #1 was asked to come into Resident #1's room and to state what she saw in regards to Resident #1's bed. CNA #1 stated, "The bed is high and it shouldn't be." When asked if this was a problem, CNA #1 stated that she (Resident #1) could get hurt if she fell out of the bed or tried to get up unassisted. When asked why the bed was so high, CNA #1 stated that she did not know. CNA #1 was asked whether or not Resident #1 should have fall mats beside her bed, CNA #1 stated that she didn't think so. When asked how she would know if Resident #1 required fall mats, CNA #1 stated, "From the Kardex (a communication tool

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used within nursing), it would come up when we were documenting care provided to (name of Resident #1)." CNA #1 was asked if she would open up Resident #1's electronic Kardex. CNA #1 and this writer reviewed Resident #1's Kardex together and fall mats were not on the Kardex. CNA #1 stated, "It (the fall mats) is not on there (the Kardex). The Kardex tells us what we need to know. It is not on there; she has nothing on the care plan for fall mats."

At approximately 4:25 p.m. RN (registered nurse) #1, the unit manager, was asked to look in Resident #1's room. At this point CNA #1 had lowered Resident #1's bed and Resident #1 was still lying in the bed. There were no fall mats on the floor beside Resident #1's bed. RN #1 was asked whether or not Resident #1 was supposed to have fall mats in place while in bed. RN #1 stated that she did not think so. RN #1 was asked to review Resident #1's care plan with this writer. The fall mats were noted on the care plan, but they had not been transferred over to the Kardex. RN #1 stated, "We never implemented fall mats to my knowledge." RN #1 was asked why the fall mats were not initiated, RN #1 stated that she did not know why.

On 8/30/17 at 11:50 a.m. an interview was conducted with ASM (administrative staff member) #3, the assistant director of nursing. ASM #3 was asked if she was aware of Resident #1 having an intervention for falls that included fall mats. ASM #3 stated that she initiated the fall mats because on observation she noticed that Resident #1 liked to lay on her right side close to the edge of the bed. ASM #3 further stated, "The fall mats were a safety precaution, in case she fell." ASM #3 was asked how the aides and

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| F 282 | Continued From page 50<br>nursing were made aware of the intervention, ASM #3 stated that she had conducted a "huddle" at the change of shift and had directed one of the aides to go get the fall mats to put in place. ASM #3 was made aware that the aides and the nursing staff stated they were unaware of the intervention. ASM #3 was asked whether or not she followed up, ASM #3 stated that she did not, she had left for vacation then next day and was away from the building for a week.<br><br>On 8/30/17 at 1:15 p.m. an end of day meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above concern. When asked if Resident #1's care plan should have been followed in respect to the fall mats, ASM #2 stated that it should have. A policy was requested related to the review and revision of care plans. This writer was provided with the section out of the RAI (resident assessment instrument) manual that provides guidance for the development, review and revision of care plans.<br><br>No further information was provided prior to the end of the survey process. | F 282 | | |
| F 309 SS=D | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>483.24 Quality of life<br>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 | F 309 | | |

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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.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, resident interview, facility document review and clinical record review, it was determined that the facility staff failed to follow physician orders for one of 19 residents in the survey sample, Resident #4.

A. The facility staff failed to administer estrogen cream, per the physician order, to Resident #4. The estrogen cream, had not been administered to Resident #4 since admission to the facility on 1/9/17.

F309 – Provide Care/Services for highest well being

1. Resident #4's MD was notified of medications not Administered. Resident #4 was assessed for any Signs or symptoms of scabies and MD reviewed for Use of vaginal cream. Orders are current and accurate..
2. Any resident with physician orders has the potential To be affected by this deficient practice.
3. Licensed nurses educated on accurate transcription of Physician orders and procedure for meds not available By DON/designee..
4. Audit of physician orders 5 times a week for 12 weeks by UM/designee for accurate transcription and medication Availability . Results of audits to QAPI monthly for 3 months For review and revisions as needed.
5. 10/4/2017

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B. The facility staff failed to administer the second dose of the Elimite cream, used to treat scabies, to Resident #4 per the physician order.

The findings include:

A. Resident #4 was admitted to the facility on 1/9/17 with diagnoses that included, but were not limited to: stroke, diabetes, depression, insomnia, and dementia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/23/17, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating that she was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance for all of her activities of daily living except eating in which she was coded as requiring supervision after set up assistance was provided.

The physician orders dated, 1/12/17 documented, "Estrace Cream 0.1 MG/GM (milligram per gram); 1 gram vaginally every night shift every 7 days related to personal history of estrogen therapy - unsupervised self-administration. Start date 1/12/17."

ESTRACE (estradiol vaginal cream, USP, 0.01%) is indicated in the treatment of vulvar and vaginal atrophy. (1)

Review of Resident #4's January, February, March, April, May, June, July, and August 2017 MAR (medication administration record) revealed the following documentation: "Estrace Cream 0.1

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MG/GM; 1 gram vaginally every night shift every 7 days related to personal history of estrogen therapy - unsupervised self-administration. Start date 1/12/17." Documented under the dates once a week, for all of the months since January, "U-SA."

Review of the comprehensive care plan dated, 1/10/17, did not reveal any documentation related to the use of Estrace Cream or self-administration of medications.

Review of the nurse's notes from 1/10/17 through 8/28/17, did not evidence anything related to the use or administration of the Estrace Cream.

An interview was conducted with LPN (licensed practical nurse) #4 on 8/30/17 at 9:30 a.m. LPN #4 was asked to review the MAR for Resident #4. When asked what "U-SA" means, LPN #4 stated that she would have to find out.

An interview was conducted with LPN #1, the unit manager, on 8/30/17 at 9:45 a.m. When shown Resident #4's MAR, and asked what "U-SA" means, LPN #1 stated, "It's unsupervised - self administration."

LPN #4 returned to this surveyor, and stated, that "U-SA means unsupervised - self administration." LPN #4 also stated, "The person who entered the order made a data entry error checking this (medication) to be self-administered."

An interview was conducted with LPN #7 on 8/30/17 at 9:55 a.m. When asked if any residents can self-administer medications, LPN #7 stated, "We don't have any resident that can self-administer medications on this unit (the unit

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on which Resident #4 resided)."

An interview was conducted with LPN #2, the unit manager of Resident #4's unit, on 8/30/17 at 9:55 a.m. When asked if residents can self-administer medications, LPN #2 stated, "No, we would need a physician's order to allow that." When asked to see the Estrace cream from the treatment cart, LPN #2 informed this surveyor that she had given the box and tube to the DON (director of nursing), ASM (administrative staff member) #2.

An interview was conducted with the ASM #2 on 8/30/17 at 10:07 a.m. This surveyor asked to see Resident #4's boxes of Estrace Cream. One box from an outside pharmacy was open and had been used. The date on the prescription label was 1/5/17. The other box of cream was from the facility pharmacy and was dated 1/12/17. This tube of Estrace Cream was not open. The MARs from January through August were reviewed with the ASM #2. ASM #2 stated, "The nurse who transcribed the order was new to electronic records. She made a data entry error." When asked how it could have gone on since January, the DON could not answer.

On 8/30/17 at 11:37 a.m. an interview was conducted with Resident #4. When asked if she receives any vaginal estrogen cream while here at the facility, Resident #4 stated, "I used it at home. I actually brought a tube with me." Resident #4 further stated, "I don't get it here, the tube is out of date."

The facility policy, "Physician Orders" did not address following the physician orders.

In "Fundamentals of Nursing" 6th edition, 2005;

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Patricia A. Potter and Anne Griffin Perry; Mosby, Inc.; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

The administrator, ASM #1 and director of nursing, ASM #2 were made aware of the above findings on 8/30/17 at 1:30 p.m.

No further information was obtained prior to exit.

(1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=7822.

B. The facility staff failed to administer the second dose of the Elimite cream, used to treat scabies, to Resident #4 per the physician order.

Review of the physician orders dated 8/15/17, documented, "Elimite Cream (Permethrin) 5%; Apply to (sic) from neck to ankles topically one time only for scabies." A second order dated 8/22/17 documented, "Elimite Cream 5%; Apply to (sic) from neck to ankles topically one time only for Scabies; Repeat in one week from first treatment."

ELIMITE (Trademark) (permethrin) 5% Cream is indicated for the treatment of infestation with Sarcoptesscabiei (scabies). (1)

Scabies is a contagious disease cause by the itch mite and characterized by itching and skin irritation, often leading to secondary infection. (2)

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Resident #4's MAR (medication administration record) for August 2017 documented, "Elimite Cream 5%; Apply to (sic) from neck to ankles topically one time only for Scabies; Repeat in one week from first treatment." Documented under the date of 8/22/17 was a "16." At the bottom of the MAR documentation revealed, "16" indicates, "Hold/See nurse's notes."

Review of the nurse's note for 8/22/17 at 7:16 p.m. documented, "Cream not available." There were no further nurse's notes for this date.

Review of the comprehensive care plan dated 1/10/17, with a reviewed on 7/17/17 date did not reveal any documentation related to the exposure to scabies and treatment.

An interview was conducted with LPN (licensed practical nurse) #6 on 8/30/17 at approximately 9:37 a.m. When asked what staff should do when a medication is not available at the time of administration, LPN #6 stated, "If we don't have it in the cart, we check the STAT (immediate) box. If it's not there we call the pharmacy to get it (medication) delivered. We notify the physician and follow their orders to either hold it or give another medication in its place."

An interview was conducted with LPN #2, the unit manager, on 8/30/17 at 9:55 a.m., regarding how many treatments a resident receives for scabies. LPN #2 stated, "Two, one week apart." The treatment cart was observed with LPN #2. A full, unopened box/tube of Permethrin Cream 5% was found in the cart. Resident #4's MAR for August 2017 was shown to LPN #2. When asked what staff should do if a medication is not available at

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| F 309 | Continued From page 57<br>the prescribed time for administration, LPN #2 stated, "They could have gotten an order to give it the next day. They have to let the family know and the doctor know. They should have called me; I'm available 24 hours a day."<br><br>An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 8/30/17 at 10:07 a.m. When asked what process staff should follow when a medication is not available at the time of administration, ASM #2 stated, "First they should look in the STAT box. If (medication is) not there, then they should call the backup pharmacy. If (medication is) not available, the nurse should call the nurse practitioner or physician to see if there is an alternate and follow the doctor's instructions." The unopened box of Elimite cream and Resident #4's MAR and nurse's notes were shared with ASM #2.<br><br>The administrator, ASM #1 and ASM #2 were made aware of the above concern on 8/30/17 at 1:30 p.m.<br><br>No further information was obtained prior to exit.<br><br>(1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c6c509bb-658e-46eb-a844-8323ecd115de.<br>(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, Rothenberg and Chapman; page 520. | F 309 | | |
| F 323 SS=D | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES | F 323 | | |

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(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.

(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 observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a safe environment free from accident hazards for two of 19 residents in the survey sample, Residents #11 and #1.

1. On 7/22/17, Resident #11 cut her leg with nail clippers. The facility staff failed to implement a plan to ensure nail clippers were not in the resident's possession after the 7/22/17 incident.

F323 – Free of accident hazards/supervision/devices

1. Resident #11 had clippers removed; care plan reviewed And is current. Resident #1 had fall mats put in place; Care plan reviewed and current..
2. Any resident with care plans with safety interventions has Potential to be affected by this deficient practice. Audit of residents with at risk for fall/injuries has had Care plan reviewed for appropriate interventions and assessed Interventions in place.
3. Nursing staff educated on following care plans to include safety Interventions by DON/designee.
4. Audit of 10 residents weekly for 12 weeks by MDS nurse/ Designee for care plan interventions in place.
5. 10/04/17

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2. The facility staff failed to place fall mats beside Resident #1's bed as directed in Resident #1's comprehensive care plan, as a safety measure for a documented fall risk.

The findings include:

1. On 7/22/17, Resident #11 cut her leg with nail clippers. The facility staff failed to implement a plan to ensure nail clippers were not in the resident's possession after the 7/22/17 incident.

Resident #11 was admitted to the facility on 8/18/14. Resident #11's diagnoses included but were not limited to: hemiplegia (1), dementia with behavior disturbance (2) and convulsions. Resident #11's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 7/14/17, coded the resident's speech as unclear. Section C coded Resident #11's cognition as severely impaired. Section E coded the resident as presenting with verbal behavioral symptoms directed toward others. Section G coded Resident 11 as requiring extensive assistance of one staff with bed mobility and transfers and as requiring supervision with set up help for eating.

Review of a facility investigation regarding Resident #11, documented by LPN (licensed practical nurse) #2 (the unit manager) revealed a report dated 7/22/17 that documented, "Resident came out of her room with a pair of nail clippers and showed (name of LPN #11) her leg, resident had used the nail clippers to cut some of her skin off on her leg. Resident showed nurse (LPN #11) her leg, and it was bleeding. (LPN #11) cleaned her leg and put bandage on the right leg where the cuts were..." Further review of the report

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revealed documentation that the resident was observed throwing objects in her room and was sent to the emergency department for a complaint of abdominal pain that same date (7/22/17) shortly after she cut her leg.

A witness statement dated by LPN #11 on 7/22/17 documented, "On July 22, 2017, I came to work at 2:45 pm. I did not encounter (Resident #11) until around 4pm. She was in her room when I started my shift, after report. There were no injuries on her that were visible to me at 3:00pm. Around 4pm she came out of her room with a pair of nail clippers and she showed me her leg. She had used the nail clippers to cut some of her skin off. She showed me the cuts and she was bleeding down her right leg. I cleaned her up, and put a bandage on her right leg..." Further review of the witness statement revealed documentation that the resident threw a radio and a glass vase in her room and then was sent to the emergency department for a complaint of abdominal pain on 7/22/17 shortly after she cut her leg.

A nurse's note dated 7/22/17 documented, "(Resident #11) was sent to the hospital due to complaint of abdominal pain. I called her daughter and her daughter said that she had complained about this before and that she should be sent out to the hospital." The note failed to reveal documentation about Resident #11 throwing objects in her room or cutting her leg with nail clippers.

Resident #11 returned to the facility from the hospital on 7/23/17. A nurse's note dated 7/23/17 documented in part, "Her right lower leg looks like 4 to 5 stitches were placed where she had tried to

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clip at her leg. However, the stitches do not appear like normally placed stitches...Finger nail clippers not in room..."

A note signed by the nurse practitioner on 7/24/17 documented, "A/P (Assessment/Plan): 1. dementia, mixed vasc (vascular) and alz (Alzheimer's) type, with Debility, needed ADL (activities of daily living) help, cont (continue) LTC (long term care), did have ed (emergency department) visit, try to avoid sharp objects as per staff was confused and cut herself..."

Resident #11's comprehensive care plan initiated on 7/17/17 documented, "Behavior Symptoms: The resident has a behavior problem r/t (related to) disease process. Resident will refuse care at times. Display verbally abusive behaviors. HX (History) of coloring on room wall. 7/22/17 Resident clipped her skin on her leg...Interventions: Monitor resident closely for self-inflicted injuries..." The care plan failed to document any interventions regarding nail clippers. Resident #11's CNA (certified nursing assistant) care kardex printed on 8/30/17 failed to document information regarding nail clippers or monitoring the resident for behaviors.

On 8/30/17 at 2:05 p.m. an interview was conducted with LPN #11 (the nurse who documented the above witness statement.) LPN #11 stated on 7/22/17 at about 4:15 p.m. Resident #11 came to her and presented with superficial cuts on her leg and nail clippers in her hand. LPN #11 stated she told the resident she would get her "cleaned up" and call her daughter. LPN #11 stated the resident returned to her room while she (LPN #11) obtained the supplies to clean her leg. When asked if she removed the

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nail clippers from Resident #11, LPN #11 stated she attempted to obtain the clippers when the resident came to her but the resident pulled her hand back and went to her room. LPN #11 stated she looked in a couple places but did not search the boxes in the resident's room because she knew that would upset the resident. LPN #11 stated Resident #11 was under her supervision from the time she bandaged her leg until the resident was sent to the emergency department.

On 8/30/17 at 3:26 p.m. an interview was conducted with LPN #2 (the unit manager). LPN #2 was asked the facility process for determining if it was safe for Resident #11 to have nail clippers. LPN #2 stated the resident should be evaluated by the physician to determine if Resident #11 was competent enough to possess nail clippers. LPN #2 was asked if Resident #11 had been assessed to determine if she should possess nail clippers. LPN #2 stated she wasn't aware of the resident being assessed. LPN #2 stated Resident #11 had use of the left side of her body and probably asked a CNA (certified nursing assistant) for nail clippers to clip her nails. LPN #2 stated the CNAs probably gave nail clippers to the resident. LPN #2 was asked if Resident #11 was now allowed to possess nail clippers. LPN #2 stated in her opinion, the resident should not have nail clippers. When asked if Resident #11 currently possessed nail clippers, LPN #2 stated, "Not that I'm aware of."

On 8/30/17 at 3:58 p.m., Resident #11 was accompanied to her room by LPN #2 and OSM (other staff member) #9 (the business office assistant who had rapport with the resident) per this surveyor's request. OSM #9 explained to Resident #11 that this surveyor questioned if the

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resident had nail clippers in her room. When OSM #9 asked the resident if she had nail clippers, Resident #11 nodded her head up and down. OSM #9 explained to Resident #11 that this surveyor wanted to see the nail clippers. Resident #11 wheeled her wheelchair to her nightstand and removed a zip lock bag containing multiple items. One pair of toenail clippers was in the bag. While exiting Resident #11's room with this surveyor, LPN #2 stated, "She must be finding a way to get them."

On 8/30/17 at 4:32 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 was asked the facility process for protecting a resident who has previously cut himself/herself with nail clippers. ASM #2 stated the resident should be kept safe, first aid should be provided and the resident's room should be searched. ASM #2 was asked if Resident #11 was assessed to determine whether it was safe for the resident to possess nail clippers after the resident cut her leg. ASM #2 stated Resident #11 should not possess nail clippers due to the resident's cognition, dexterity and history of a stroke. ASM #2 stated she thought it would not be safe for Resident #11 to possess nail clippers. ASM #2 was asked what interventions were implemented to ensure Resident #11 did not possess nail clippers. ASM #2 stated the CNAs should check to make sure the resident doesn't have nail clippers when providing care and CNAs should make sure Resident #11's call bell is left on the resident's bed close to the door so the resident can reach the call bell. ASM #2 was asked how the CNAs should be made aware Resident #11 should not possess nail clippers. ASM #2 stated the information should be documented on the

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resident's care plan and the CNA care kardex. At this time, ASM #2 was made aware this information was not documented on Resident #11's care plan or kardex. ASM #2 was also made aware toenail clippers were found in Resident #11's room.

On 8/30/17 at 5:00 p.m. an interview was conducted with CNA #3 (one of Resident #11's primary CNAs on the 3:00 p.m. to 11:00 p.m. shift). CNA #3 was asked if she had been made aware of any special items she should check for in Resident #11's room. CNA #3 stated Resident #11 was very particular about people touching her belongings but she (CNA #3) went through the resident's belongings during the previous week and nothing was in the boxes. CNA #11 was asked if the resident was not supposed to have any particular objects in her room. CNA #3 stated Resident #11 wasn't supposed to have razors. Also, CNA #11 stated the resident wasn't supposed to have any sharp objects but that pertained to all residents. CNA #3 was asked how often she checks Resident #11's room. CNA #3 stated she checks the room as often as she can but that was probably once or twice every couple of weeks because the resident "stands guard." CNA #3 was asked if Resident #11 was supposed to have nail clippers. CNA #3 stated, "I'm not sure." CNA #3 was asked if the resident had any past incidents with nail clippers. CNA #3 stated, "Yes. I forgot. I was off that day. She cut a spot in her leg." CNA #3 was asked if she had received any special instructions or education regarding Resident #11's possession of nail clippers or monitoring the resident's room. CNA #3 stated she had not.

On 8/30/17 at 5:36 p.m., ASM (administrative

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staff member) #1 (the administrator) and ASM #2 were made aware of the above findings. Policies regarding safety risk assessments and self-injurious behaviors were requested.

The facility policy titled, "Behavior Management" documented, "A. Admission/Readmission and New Onset of Behaviors. 1. Upon Admission/Readmission and/or the new onset of a behavior that would negatively impact the resident the licensed nurse will complete a Pain Interview Form and an Incident/Accident Report if applicable. Complete a SBAR (situation, background, assessment, recommendation) to identify any possible contributing factors. The attending physician and responsible party will be notified of significant findings. Any physician orders received will be appropriately transcribed and implemented. If the resident presents with behaviors that will harm him/her or others, then the state specific protocol needs to be initiated as applicable..."

No further information was presented prior to exit.

(1) Hemiplegia- "Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=hemiplegia

(2) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or

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eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.224943194.1157683707.1504190243-139120270.1477942321

2. The facility staff failed to place fall mats beside Resident #1's bed as directed in Resident #1's comprehensive care plan, as a safety measure for a documented fall risk.

Resident #1 was admitted to the facility on 6/27/17 with diagnoses that included, but were not limited to, pressure ulcers, pain, high blood pressure, high lipid levels in the blood stream, respiratory failure and peripheral vascular disease.

Resident #1's most recent comprehensive MDS (minimum data set) was an admission assessment with an ARD (Assessment reference date) of 7/5/17. Resident #1 scored an 11 out of a possible 15 on her BIMS (brief interview of mental status) indicating that she is cognitively moderately impaired with daily decision making. Resident #1 was also coded in Section V as having a CAA (care area assessment) trigger of falls.

A review of Resident #1's comprehensive care plan dated 6/28/2016 revealed, in part, the

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following documentation; "Focus: At high risk for falls/impaired safety r/t (related to) decline in function, pain management, Hx (history) of UTI (urinary tract infection), respiratory failure. 7/21/17 Fall r/t resident being lowered to the floor without injury. Interventions: Fall matts (sic) at bedside to help prevent injuries in case of a fall. Date Initiated: 8/22/2017. Maintain safe environment. Date Initiated: 6/28/2017. Instruct on appropriate safety measures. Date initiated: 7/22/2017."

Resident #1 was observed on 8/28/17 at 3:15 p.m. in her room, lying in her bed. Resident #1 stated that she had just had her pressure ulcer dressings changed and was resting. There were no fall mats observed on the floor beside the bed.

Resident #1 was observed on 8/29/17 at 4:20 p.m. in her room lying in her bed. The bed was observed at an elevated height, and there were no fall mats on the floor beside the bed. At this time CNA (certified nursing assistant) #1 was asked to come into Resident #1's room and to state what she saw in regards to Resident #1's bed. CNA #1 stated, "The bed is high and it shouldn't be." When asked if this was a problem, CNA #1 stated that she (Resident #1) could get hurt if she fell out of the bed or tried to get up unassisted. When asked why the bed was so high, CNA #1 stated that she did not know. CNA #1 was asked whether or not Resident #1 should have fall mats beside her bed, CNA #1 stated that she didn't think so. When asked how she would know if Resident #1 required fall mats, CNA #1 stated, "From the Kardex (a communication tool used within nursing), it would come up when we were documenting care provided to (name of Resident #1)." CNA #1 was asked if she would

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open up Resident #1's electronic Kardex. CNA #1 and this writer reviewed Resident #1's Kardex together and fall mats were not on the Kardex. CNA #1 stated, "It (the fall mats) is not on there (the Kardex). The Kardex tells us what we need to know. It is not on there; she has nothing on the care plan for fall mats."

At approximately 4:25 p.m. RN (registered nurse) #1, the unit manager, was asked to look in Resident #1's room. At this point CNA #1 had lowered Resident #1's bed and Resident #1 was still lying in the bed. There were no fall mats on the floor beside Resident #1's bed. RN #1 was asked whether or not Resident #1 was supposed to have fall mats in place while in bed. RN #1 stated that she did not think so. RN #1 was asked to review Resident #1's care plan with this writer. The fall mats were noted on the care plan, but they had not been transferred over to the Kardex. RN #1 stated, "We never implemented fall mats to my knowledge." RN #1 was asked why the fall mats were not initiated, RN #1 stated that she did not know why.

On 8/30/17 at 11:50 a.m. an interview was conducted with ASM (administrative staff member) #3, the assistant director of nursing. ASM #3 was asked if she was aware of Resident #1 having an intervention for falls that included fall mats. ASM #3 stated that she initiated the fall mats because on observation she noticed that Resident #1 liked to lay on her right side close to the edge of the bed. ASM #3 further stated, "The fall mats were a safety precaution, in case she fell." ASM #3 was asked how the aides and nursing were made aware of the intervention, ASM #3 stated that she had conducted a "huddle" at the change of shift and had directed one of the

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| F 323 | Continued From page 69<br>aides to go get the fall mats to put in place. ASM #3 was made aware that the aides and the nursing staff stated they were unaware of the intervention. ASM #3 was asked whether or not she followed up, ASM #3 stated that she did not, she had left for vacation then next day and was away from the building for a week.<br><br>On 8/30/17 at 1:15 p.m. an end of day meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above concern. When asked if Resident #1's care plan should have been followed in respect to the fall mats, ASM #2 stated that it should have. A policy was requested related to the review and revision of care plans. This writer was provided with the section out of the RAI (resident assessment instrument) manual that provides guidance for the development, review and revision of care plans.<br><br>No further information was provided prior to the end of the survey process. | F 323 | | |
| F 371 SS=D | 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable | F 371 | | |

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safe growing and food-handling practices.

(iii) This provision does not preclude residents from consuming foods not procured by the facility.

(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined that the facility staff failed to serve food in a sanitary manner and store mops in a sanitary manner in the kitchen.

A. The fryer had food particles floating in the vat of oil and food particles on the front ledge of the fryer.

B. A mop in the kitchen was positioned with the mop sitting in the water. No staff member was observed around or using the mop.

The findings include:

A. Observation was made of the kitchen on 8/28/17 at 10:09 a.m. accompanied by OSM (other staff member) #2, the dietary manager. A deep fryer was observed on the wall of the kitchen. A sheet pan was covering the fryer. When the pan was lifted, food debris and food particles' were observed floating in the oil and on the ledge of the fryer. When asked if the fryer

F371 – Food procure, store/prepare/serve – sanitary

1. Mop found to be stored inappropriately was stored appropriately and fryer was cleaned during survey.
2. Any resident receiving dietary services has the potential to be Affected by this deficient practice.
3. Dietary staff educated on cleaning procedures and mop storage by Dietary manager.
4. Audit of kitchen 3 times a week for 12 weeks by Administrator/designee for cleanliness and appropriate Storage of cleaning supplies. Results of audit To QAPI monthly for 3 months for review and revision As needed.
5. 10/4/2017

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was ready for use, OSM #2 stated, "Yes." When asked when the fryer was last used, OSM #2 stated, "I believed it was Saturday." When asked the process for cleaning the fryer, OSM #2 stated, "It is to be scooped out after each use." When shown the fryer, OSM #2 stated, "That should have been cleaned after it was used."

The facility policy, "Cleaning Instructions: Deep Fat Fryer" documented in part, "Policy: Deep fat fryer will be cleaned and the oil strained after each use. The oil will be replaced as needed and according to the cleaning schedule."

The administrator and director of nursing were made aware of the above findings on 8/29/17 at 5:45 p.m.

No further information was obtained prior to exit.

B. A mop in the kitchen was positioned with the mop sitting in the water. No staff member was observed around or using the mop.

Observation was made of the kitchen on 8/28/17 at 10:09 a.m. accompanied by OSM (other staff member) #2, the dietary manager. A bucket with cleaning solution was noted near the door to the dining room. The mop was sitting in the water with cleaning solution. There was no staff member near the bucket. When asked if the mop should be stored in the water when not in use, OSM #2 stated, "No, Ma'am. It should be up in the basket when not in use." A copy of the policy on the use and storage of mops was requested.

On 8/28/17 at 12:24 p.m. OSM #2 informed this surveyor that the facility did not have a policy on the storage of mops.

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| F 371 | Continued From page 72<br><br>The administrator and director of nursing were made aware of the above findings on 8/29/17 at 5:45 p.m.<br><br>No further information was provided prior to exit. | F 371 | | |
| F 431 SS=D | 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>(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.<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--<br><br>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>(g) Labeling of Drugs and Biologicals.<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted | F 431 | | |

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professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined that the facility staff failed to appropriately label and store medications in one of two medication rooms, the south unit medication room.

One opened bottle of lorazepam intensol (1) was not labeled with an open date in the south unit medication room. Also, one expired saline laxative enema (2) was observed in the south unit medication room.

The findings include:

On 8/30/17 at 10:27 a.m. observation of the south unit medication room was conducted with LPN

F431 – Drug records, label/store drugs and biologicals

1. 1 Medications/treatments past expiration date removed And destroyed appropriately.
2. Any resident receiving medications/treatments has The potential to be affected by this deficient practice. Audit of medication rooms and med carts competed for Appropriate storage and expired medications/treatments.
3. Licensed Nurses educated on appropriate medication storage To include labeling open medications and discarding expired Medications by DON/designee.
4. Unit Managers/designee will audit medication rooms and medicati Carts weekly for 12 weeks to ensure proper medication storage. Results of audits to QAPI monthly for 3 months for review and revisions as needed.
5. 10/4/2017

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(licensed practical nurse) #10. One opened bottle containing approximately 20 milliliters of lorazepam intensol was observed. Neither the bottle nor the manufacturer's box containing the bottle was labeled with an open date. The pharmacy label documented the medication was sent to the facility on 1/19/17. The manufacturer's instructions on the box documented, "Discard opened bottle after 90 days." LPN #10 was asked if there were any special instructions or expiration date for opened bottle of lorazepam intensol. LPN #10 stated, "We haven't been told. I can call the pharmacy and find out." LPN #10 was shown the documentation on the lorazepam intensol box. LPN #10 stated "Oh. So it's no good." At this time, LPN #2 (the unit manager) entered the room. LPN #2 confirmed the bottle and the box were not labeled with an open date. LPN #2 stated the medication needed to be destroyed.

Further observation of the room revealed a saline laxative enema with a manufacturer's expiration date of March 2017. LPN #10 confirmed the enema was expired and discarded the contents.

On 8/30/17 at 1:31 p.m. ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility/pharmacy policy titled "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" documented, "4. Facility should ensure that medications and biologicals...4.2 Have not been retained longer than by manufacturer or supplier guidelines..."

No further information was presented prior to exit.

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| F 431 | Continued From page 75<br><br>(1) Lorazepam intensol is used to relieve anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682053.html<br><br>(2) Saline laxative enemas are used to empty the colon. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a609019.html | F 431 | | |
| F 441 SS=D | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(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);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; | F 441 | F441 – Infection control, prevent spread, linens<br><br>1. Infection control log was reviewed and corrected As appropriate.<br>2. Any resident in facility has potential to be affected by This deficient practice. Review of infection control log August reviewed for accuracy and completeness<br>3. Nurse Management team educated on maintaining An accurate and complete infection control log by Regional Director of Clinical Services.<br>4. Audit of infection control log weekly by UM/designee for 12 weeks for accuracy and completeness. Results of audits Taken to QAPI monthly for 3 months for review and revision as needed.<br>5. 10/4/2017 | |

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(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
(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.

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This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review, it was determined that the facility staff failed to maintain a complete infection control program, as evidenced by incomplete infection control logs for the month of August 2017.

The facility staff failed to document Resident #2 who was treated for scabies during August of 2017 on the August infection control logs.

The findings include:

The infection control logs for August 2017 were reviewed. The entries were dated 8/1/17 through 8/26/17.

A review of Resident #2's clinical record documented the resident was treated for actual scabies on 8/15/17. Resident #4 in the survey sample was treated prophylactically as she was Resident #2's roommate.

Scabies is a contagious disease caused by the itch mite characterized by itching and skin irritation, often leading to secondary infection. (1)

Resident #2 was admitted to the facility on 3/6/17 with diagnoses, that included, but were not limited to: emphysema (abnormal condition of the lungs in which there is over inflation of the air sacs of the lungs, leading to a breakdown of their walls, and a decrease in respiratory function) (1), edema, history of breast cancer, dementia, and gastroesophageal reflux disease (backflow of the contents of the stomach into the esophagus) (2).

The most recent MDS (minimum data set)

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assessment, a quarterly assessment, with an assessment reference date of 8/4/17, coded the resident as scoring a six on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make cognitive daily decisions.

Resident #4 was admitted to the facility on 1/9/17 with diagnoses that included, but were not limited to: stroke, diabetes, depression, insomnia, and dementia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/23/17, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating that she was cognitively intact to make daily decisions.

Neither resident appeared on the infection control logs.

An interview was conducted with administrative staff member (ASM) #3, the assistant director of nursing, on 8/29/17 at 10:05 a.m. When asked if her infection control logs were up to date, ASM #3 stated, "Yes, they are." When asked if the facility has had any residents that have been diagnosed with scabies, ASM #3 stated, "Yes, (name of Resident #2)." When asked if any other resident was treated for scabies, ASM #3 stated, "Yes, her roommate, (name of Resident #4) was treated prophylactically." When asked if a resident with scabies should be on the infection control logs, ASM #3 stated, "Yes, it should." ASM #3 was asked to review the August 2017 infection control logs. When asked if she had documented the infection of scabies for Resident #2, ASM #3

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| F 441 | Continued From page 79<br>stated, "no, Ma'am."<br><br>An interview was conducted with ASM #2, the director of nursing, on 8/29/17 at 11:08 a.m. When asked if the facility has had any resident with scabies in the past month, ASM #2 stated, "Yes, (name of Resident #2). The doctor at PACE (programs of All-Inclusive Care of the Elderly) diagnosed her with scabies on a Tuesday. We had her treated and transferred to a private room. Her roommate was also treated prophylactically and placed in a private room." When asked if any resident with scabies should be documented on the infection control logs, ASM #2 stated, "Absolutely." ASM #2 was asked to review the infection control logs for August 2017. When asked if she saw Resident #2 or Resident #4 on the infection control logs, ASM #2 stated, "No, I don't."<br><br>The facility policy, "Infection Prevention and Control Committee" documented in part, "A. Monthly Infection Control Log for individual nursing units is used to (sic) and trend infections by site and organism on a unit."<br><br>The administrator and director of nursing were made aware of the above findings on 8/29/17 at 5:45 p.m.<br><br>No further information was provided prior to exit.<br><br>(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader 5th edition, Rothenberg and Chapman; page 520. | F 441 | | |
| F 465 SS=D | 483.90(i)(5)<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON | F 465 | | |

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| F 465 | Continued From page 80 | F 465 | | |

(i) Other Environmental Conditions

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, it was determined that the facility staff failed to store chemicals in a safe manner in one of two shower rooms, the north unit shower room.

Three containers of germicidal wipes, one bottle of odor remover and one bottle of disinfectant were observed in an unlocked shower room on the north unit.

The findings include:

On 8/30/17 at 8:45 a.m. observation of the unlocked north unit shower room was conducted. No one was in the shower room and no residents were observed near the shower room. The following was observed:
-One container of germicidal wipes was observed on top of a plastic cabinet that was sitting on the floor.
-Two containers of germicidal wipes, one bottle of odor remover and one bottle of disinfectant were observed inside the plastic cabinet. The cabinet contained a lock but was not locked.

F465 – Safe/functional/sanitary/comfortable environment

1. Chemicals in shower room were stored appropriately during survey
2. Any resident has potential to be affected by this deficient practice. Both shower rooms were checked for appropriate chemical storage
3. Nursing and housekeeping staff educated on appropriate Storage of chemicals by Administrator/designee.
4. Audit of shower rooms 5 times a week for 12 weeks by Maintenance director/designee for appropriate chemical Storage. Results of audits to QAPI monthly for 3 months For review and revision as needed.
5. 10/4 2017

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| F 465 | Continued From page 81<br>On 8/30/17 at 9:14 a.m. OSM (other staff member) #4 (the maintenance director) was asked to observe the north unit shower room with this surveyor. OSM #4 was shown the chemicals. OSM #4 was asked if the chemicals should be stored in an unsecured manner. OSM #4 stated, "No. That's why I got the cabinet and the lock." OSM #4 stated all chemicals should be locked in the cabinet. At this time a policy regarding the storage of chemicals was requested.<br><br>On 8/30/17 at 10:08 a.m. OSM #4 stated the facility did not have the requested policy.<br><br>On 8/30/17 at 1:31 p.m. ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.<br><br>The safety data sheet for the germicidal wipes documented, "Causes irreversible eye damage. Harmful if absorbed through skin..."<br>The safety data sheet for the odor remover documented, "Causes mild skin irritation. Causes eye irritation..."<br>The safety data sheet for the disinfectant documented, "Causes severe skin burns and eye damage..."<br><br>No further information was presented prior to exit. | F 465 | | |
| F 503 SS=D | 483.50(a)(i)-(iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT<br><br>(a) Laboratory Services<br><br>(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 | F 503 | | |

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| F 503 | Continued From page 82 of this chapter.<br><br>(ii) If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in part 493 of this chapter.<br><br>(iii) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter.<br><br>(iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview it was determined that the facility staff failed to ensure one of two medication rooms was free of expired laboratory supplies, the north unit medication room.<br><br>Ten expired sterile culture transport swabs and one expired blood collection tube were observed in the north unit medication room.<br><br>The findings include:<br><br>On 8/30/17 at 12:15 p.m. observation of the north unit medication room was conducted with LPN (licensed practical nurse) #6. The following was observed:<br><br>-Two sterile culture transport swabs with an | F 503 | F503 – Lab services – Facility provided, referred, agreement<br><br>1. Expired sterile transport swabs and one blood collection tube that was expired were discarded during survey.<br>2. Any resident has potential to be affected by this Deficient practice.<br>Audit of both medication rooms were conducted For expired lab products.<br>3. Licensed Nurses educated on appropriate storage of Lab supplies to include reviewing for expiration by DON/designee.<br>4. Unit Managers/designee will audit medication rooms Weekly for 12 weeks for appropriate storage/expiration Of lab supplies. Results of audits to QAPI monthly for 3 months for review and revision as needed.<br>5. 10/4/2017 | |

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| F 503 | Continued From page 83<br>expiration date of May 2017.<br>-Eight sterile culture transport swabs with an expiration date of July 2017.<br>-One blood collection tube with an expiration date of July 2017.<br><br>LPN #6 confirmed the supplies were available for use and were expired. LPN #6 was asked who was responsible for checking the lab supplies and how often should they be checked. LPN #6 stated all nurses who had access to the room were responsible and the supplies should be checked every shift.<br><br>On 8/30/17 at 1:31 p.m. ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. A policy regarding expired lab supplies was requested.<br><br>The facility/pharmacy policy titled, "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" failed to document specific information regarding lab supplies.<br><br>According to applicable requirements for laboratories specified in Part 493 of this chapter: § 493.1252 Standard: Test systems, equipment, instruments, reagents, materials, and supplies.(4) (d) Reagents, solutions, culture media, control materials, calibration materials, and other supplies must not be used when they have exceeded their expiration date, have deteriorated, or are of substandard quality.<br><br>No further information was presented prior to exit. | F 503 | | |
| F 507 SS=D | 483.50(a)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS | F 507 | | |

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| F 507 | Continued From page 84 | F 507 | | |

(a) Laboratory Services

(2) The facility must-

(iv) File in the resident's clinical record laborat reports that are dated and contain the name a address of the testing laboratory.
This REQUIREMENT is not met as evidence by:
Based on staff interview, facility document re and clinical record review, it was determined the facility staff failed to ensure that a laborat result was in the clinical record for one of 19 residents in the survey sample, Resident #7.

The facility staff failed to obtain the results for laboratory tests obtained on 7/6/17 and place them in Resident #7's clinical record for physi review.

The findings include:

Resident #7 was admitted to the facility on 5/27/17 with diagnoses that included, but were not limited to; low red blood cell count, high blood pressure, diabetes, arthritis, pain, cardiovascular disease and encephalopathy (swelling of the brain).

Resident #7's most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/2/17 revealed, in part, that Resident #7 scored a 12 out of a possible 15 on his BIMS (brief interview of mental status), indicating that Resident #7 is cognitively moderately impaired to make daily decisions.

F507 – Lab reports in record – lab name/address

1. Resident #7's lab was uploaded to EHR during survey.
2. Residents receiving lab services have the potential To be affected by this deficient practice. Labs reviewed for August to ensure results received and part of residents' clinical record.
3. Licensed nurses educated on obtaining lab results and medical Record clerk educated on timely filing results into clinical record by DON/designee.
4. Unit Managers/designee will audit 5x/week for 12 weeks to Ensure lab results obtained and part of resident clinical record. Results of audits will be taken to QAPI monthly for 3 months for review And revisions as needed..
5. 10/4/2017

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A review of Resident #7's clinical record revealed a laboratory order to be completed starting on 7/6/17. The laboratory order was for a CBC (complete blood count) [1], a CMP (complete metabolic panel) [2], and a hgbA1c (hemoglobin A1C) [3].

Further review of Resident #7's clinical record failed to reveal the results of the laboratory tests in the record.

On 8/29/17 at 10:27 a.m. ASM (administrative staff member) #2, the director of nursing, was asked to provide evidence the laboratory tests, ordered for Resident #7 on 7/6/17, were completed. ASM #2 reviewed the clinical record and was unable to locate the laboratory test results and asked for time to do some research to find the documents.

On 8/29/17 at 12:04 p.m. RN (registered nurse)) #1, the unit manager stated that she was unable to locate the evidence of the laboratory tests being completed in medical records. RN #1 stated she had called the laboratory site and they had faxed a copy, RN #1 further stated, "We did not have it, I had to call to get it." When asked if the physician or nurse practitioner had seen the results RN #1 was unable to say. RN #1 was asked to describe the process for ensuring laboratory results were on the clinical record. RN #1 stated, "When a laboratory test is ordered we put it in the lab (laboratory) book, when the lab comes back we check off in the book which is kept in the DON's (director of nursing's) office. The unit managers collect all labs to ensure that they are drawn (collected) then give them to the nurses on the unit who put them in the physician/nurse practitioner book."

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On 8/29/17 at 5:45 p.m. an end of day meeting was held with ASM #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above concern and a policy regarding ensuring that laboratory results were on the clinical record was requested.

A review of the facility document "Lab/Diagnostic Test Tracking Protocol" was provided by the facility staff and revealed, in part, the following documentation: "6) When the results are reported to the facility, the nurse receiving the results will immediately report any abnormal results to the physician, and document time and date reported, and if there were any new orders from the physician on the log."

No further information was provided prior to the end of the survey process.

[1] A complete blood count test measures several components and features of your blood. This information was obtained from the following website;
http://www.mayoclinic.org/tests-procedures/complete-blood-count/home/ovc-20257165

[2] The A1C test is a common blood test used to diagnose type 1 and type 2 diabetes and then to gauge how well you're managing your diabetes. This information was obtained from the following website;
http://www.mayoclinic.org/tests-procedures/a1c-test/home/ovc-20167930

[3] Comprehensive metabolic panel is a group of blood tests. They provide an overall picture of your body's chemical balance and metabolism.

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| F 507 | Continued From page 87<br>Metabolism refers to all the physical and chemical processes in the body that use energy. This information was obtained from the following website;<br>https://medlineplus.gov/ency/article/003468.htm | F 507 | | |
| F 514 SS=D | 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>(i) Medical records.<br>(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br><br>(i) Complete;<br><br>(ii) Accurately documented;<br><br>(iii) Readily accessible; and<br><br>(iv) Systematically organized<br><br>(5) The medical record must contain-<br><br>(i) Sufficient information to identify the resident;<br><br>(ii) A record of the resident's assessments;<br><br>(iii) The comprehensive plan of care and services provided;<br><br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br><br>(v) Physician's, nurse's, and other licensed professional's progress notes; and | F 514 | F514 – Resident records – complete/accurate/accessible<br><br>1. Resident #11's medical record was reviewed and Current concerns have been addressed.<br>2. Any resident with behaviors have potential to be Affected by this deficient practice. Residents with behaviors as generated by MDS have Been reviewed for necessary documentation.<br>3. Licensed nurses educated on accurate and complete Documentation of resident's exhibiting behaviors by DON/designee..<br>4. Social service staff/designee will audit weekly for 12 weeks Clinical records of residents exhibiting behaviors for appropriate Documentation. Results of audits to QAPI monthly for 3 months for review and revision as needed.<br>5. 10/4/2017 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495244 | A. BUILDING _____ B. WING _____ | C 08/30/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF MADISON | NUMBER ONE AUTUMN COURT MADISON, VA 22727 |

| (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 |
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(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, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 19 residents in the survey sample, Resident #11.

The facility staff failed to document Resident #11 cut her leg with nail clippers and threw objects in her room on 7/22/17.

The findings include:

Resident #11 was admitted to the facility on 8/18/14. Resident #11's diagnoses included but were not limited to: hemiplegia (1), dementia with behavior disturbance (2) and convulsions. Resident #11's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 7/14/17, coded the resident's cognition as severely impaired.

Review of a facility investigation regarding Resident #11, documented by LPN (licensed practical nurse) #2 (the unit manager) revealed a report dated 7/22/17 that documented, "Resident came out of her room with a pair of nail clippers and showed (name of LPN #11) her leg, resident had used the nail clippers to cut some of her skin off on her leg. Resident showed nurse (LPN #11) her leg, and it was bleeding. (LPN #11) cleaned her leg and put bandage on the right leg where the cuts were..." Further review of the report revealed documentation that the resident was observed throwing objects in her room and was

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sent to the emergency department for a complaint of abdominal pain.

A witness statement dated by LPN #11 on 7/22/17 documented, "On July 22, 2017, I came to work at 2:45 pm. I did not encounter (Resident #11) until around 4pm. She was in her room when I started my shift, after report. There were no injuries on her that were visible to me at 3:00pm. Around 4pm she came out of her room with a pair of nail clippers and she showed me her leg. She had used the nail clippers to cut some of her skin off. She showed me the cuts and she was bleeding down her right leg. I cleaned her up, and put a bandage on her right leg..." Further review of the witness statement revealed documentation that the resident threw a radio and a glass vase in her room and then was sent to the emergency department for a complaint of abdominal pain.

A nurse's note dated 7/22/17 documented, "(Resident #11) was sent to the hospital due to complaint of abdominal pain. I called her daughter and her daughter said that she had complained about this before and that she should be sent out to the hospital." The note failed to reveal documentation of Resident #11 throwing objects in her room or cutting her leg with nail clippers.

On 8/30/17 at 2:05 p.m. an interview was conducted with LPN #11. LPN #11 was asked why she didn't document Resident #11 cut her leg with nail clippers or document the resident threw objects in her room on 7/22/17 in Resident #11's clinical record. LPN #11 stated she thought she did document the information.

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On 8/30/17 at 4:32 p.m. an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 was asked if Resident #11's behaviors of cutting herself with nail clippers and throwing objects should be documented in the resident's clinical record. ASM #2 stated, "Oh my gosh yes." ASM #2 confirmed the facility investigation and witness statement was part of a soft file and not part of Resident #11's clinical record. ASM #2 was asked to review the resident's clinical record and provide evidence that the resident's behaviors of cutting herself and throwing objects was documented.

On 8/30/17 at 5:36 p.m. ASM #1 (the administrator) and ASM #2 were made aware of the above concern.

The facility policy titled, "Nurse Progress Notes" documented, "POLICY: A resident's progress shall be documented in the record as required. PROCEDURE: 1. The nurse shall utilize the Progress Note to document resident progress..."

No further information was presented prior to exit.

(1) Hemiplegia- "Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=hemiplegia

(2) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with

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| F 514 | Continued From page 91<br>dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.224943194.1157683707.1504190243-139120270.1477942321 | F 514 | | |