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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF VIRGINIA	1600 JOHN ROLFE PARKWAY RICHMOND, VA 23233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Citation Text for Tag 0000, Regulation FF10 An unannounced Medicare/Medicaid standard survey was conducted 1/30/17 through 2/1/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 116 certified bed facility was 89 at the time of the survey. The survey sample consisted of 15 current Resident reviews (Residents #1 through #15) and 3 closed record reviews (Residents #16 through #18).	F 000	**Beth Sholom Home** **Plan of Correction** **This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited during the survey of February 1, 2017. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law.**	
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.	F 225	Criterion 1 Resident #4: the finding of a bruise to her bilateral hands on 11/30/16 has been reported as a bruise of unknown origin to the Office of Licensure and Certification, as of 2/13/17. The investigation did not conclude that the bruises resulted from abuse. Her care plan has been updated to reflect the placement of a soft towel or cloth at the table's edge during meals to prevent the risk of recurrent bruising. There has been no further bruising of this nature and the intervention has been effective.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
, CAHQ	Administrator	2/16/17

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 225	Continued From page 1 (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey	F 225	Resident #18 is no longer a resident of the facility. The finding of a bruise to her right arm on 9/25/16 has been reported as a bruise of unknown origin to the Office of Licensure and Certification, as of 2/13/17. The investigation of this bruise did not conclude that it resulted from abuse. Resident #9: the finding of a bruise to her left upper arm on 11/18/16 has been reported as a bruise of unknown origin to the Office as of 2/13/17. The resident's care plan, which addressed the risk of bruising related to anticoagulation therapy and fragile skin, had been updated on 11/17 to include geri-sleeves to her upper arms, and this intervention has been effective. Staff also has been alerted to the risk of bruising related to the resident leaning with her arm between body and wheelchair. This risk has also been identified on her care plan with updated interventions.	

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Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation and clinical record review, the facility staff failed to investigate and report to the Office of Licensure and Certification (OLC) injuries of unknown origin for three residents (Residents #4, #18, and #9), in a survey sample of 18 residents.

1. For Resident #4, bilateral bruising to both hands was identified on 11/30/16. The injury of unknown origin was not reported to the OLC.

2. For Resident #18, a bruise was identified on her right arm on 9/25/16. The injury of unknown origin was not investigated or reported to the OLC.

3. For Resident #9, the facility did not report a bruise of unknown origin to the OLC.

The findings included:

1. Resident #4 was admitted to the facility on 10/29/12. Diagnoses included stroke, arthritis, glaucoma, muscle weakness, and dysphasia.

Resident #4's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/12/16 was coded as a quarterly assessment. The resident was coded as having a BIMS (brief interview mental status) of "00" out of a possible 15, or severe cognitive impairment. Resident #4 was also coded as requiring extensive assistance of one to two staff members to perform activities of daily living (ADL's), but was totally dependent

Criterion 2
All residents are potentially affected by a failure to investigate and report injuries of unknown origin to the state survey agency. The facility will review active resident records for the 90 days preceding the survey (November 1, 2016 through January 31, 2017) to identify any other residents who have had bruises or other indications of injury that had potential for being signs of abuse. The facility will review any identified injuries and fulfill reporting and investigating requirements.

Criterion 3
The facility will provide in-service training on reporting and investigating injuries of unknown origin to the nursing staff. The in-service will include information on how to properly document an assessment of an injury (including etiology when known), principles of investigating injuries of unknown origin and regulations governing the reporting of injuries of unknown origin. The in-service will be followed by post-testing to ensure understanding.

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on staff for dressing and toileting.

Resident #4 was observed on 1/31/17 at 9:30 a.m. She was observed sitting in chair in the hallway in front of the nursing station. Resident #4 was well dressed, wearing protective cloth sleeves on both arms and her left arm was in a splint device. Resident #4 exhibited a pleasant affect and was very complimentary during her conversation.

A review of the clinical record was conducted on 1/31/17 at 9:45 a.m.

Review of the comprehensive care plan revealed a care plan for Resident #4's risk for impaired skin related to history of ASA (aspirin) use, incontinence and impaired mobility.

Review of the clinical record revealed nurse's note that read:
"11/30/16 - This writer in to give scheduled breathing treatment and noted several bruises. Bilateral bruising noted to the back of both hands. (L) hand bruising very dark in color (plum purple) along with middle and ring finger. Some swelling noted (R) hand bruising light purple in color no swelling noted. Resident expressed no signs of discomfort. Doctor on unit and made aware. Message left to RP (Responsible Party)."

Review of a Weekly Skin Assessment dated 11/24/16 revealed 'No Bruises" were observed.

On 1/31/17 at 3:30 p.m., Admin. D provided a copy of the investigation regarding the bruise that was identified on 11/30/16. Information included the following:
a. Under Details or Information Regarding the

F 225 Shift supervisors will also receive in-service training on the proper way to complete an initial Facility Report of Incident (FRI) form when an injury of unknown origin is first identified. The supervisors on each shift will be responsible to complete and transmit this information 24 hours per day, and to subsequently initiate the investigation into the etiology of the injury. All injuries of unknown origin will be identified on the shift report until the investigation is concluded. The facility's Abuse Prevention policy has been revised to specifically identify that all reports of incidents (including injuries of unknown origin) will be reported immediately; this change will be included in the in-service training provided to staff.

Criterion 4
The VP QA (or designee in her absence) will maintain a log listing of bruises of unknown origin. The log will be used to monitor the timely reporting of these injuries, the date of completion of the investigation and the reporting of the results to the state agency. Review of the log will be done at least weekly with any omissions noted in a monthly report to the QA Committee.

Completion Date: March 2, 2017

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Injury read, "Per son, he states he saw them (the bruises) earlier today, spoke with three staff members but no one could tell him how it happened."

b. Under QA (quality assurance) Review -Investigation Conclusion read, "Injury most likely resulted from - D.O.N. (Director of Nursing) reports resident bumps top surfaces of hands while attempting to self feed in dining room, - towel placed at edge to reduce risk of injury and bruising." signed and dated 12/6/16 by Admin D.

Further review of the comprehensive care plan did not reveal any interventions to prevent Resident #4 from bumping the top surfaces of her hands or for placing a towel at edge to reduce risk of injury and bruising.

On 1/31/17 at 5:15 p.m., during an end of day meeting, the administrator, DON and Admin. D were asked if the bruises/injury of unknown origin was reported to the State Agency Office of Licensure and Certification. Admin D stated, "We investigated the incident and found nothing suspicion." The DON stated, "We do notify if we can't find any reason within the timeframe."

The facility Abuse Prevention, Investigation and Reporting Policy read:
a. Under Investigation read, "The facility will investigate and report incidents or occurrences to the state survey and other interested agencies in accordance with federal and state regulations..."
b. Under Reporting/Response read, "The Administrator will report all alleged violations and all substantiated incidents to the state agency..... Allegations that have resulted in no serious harm to the resident may be reported within 24 hours."

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Resident #4's bruises to her hands were injuries of an unknown source, and therefore considered an alleged violation. There was no documentation, witness or staff statements as to the cause of Resident #4's bruises. The DON's presumption of the cause of the bruises was documented in the conclusion of the facility's investigation on 12/6/16, six days after the incident.

On 2/1/17 at 1:00 p.m., the administration was informed of the facility staff's failure to immediately report Resident #4's bruises of unknown origin to the Office of Licensure and Certification (OLC). No additional information was provided.

2. For Resident #18, a bruise was identified on her right arm on 9/25/16. The injury of unknown origin was not investigated or reported to the OLC.

Resident #18 was admitted to the facility on 9/9/16. Diagnoses included fracture of the fourth lumbar vertebra, falls, arthritis, hypertension, depressive disorder. Resident #18 was discharged from the facility on 12/12/16. A closed record review was conducted.

Resident #18's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/16/16 was coded as an admission assessment. The resident was coded as having a BIMS (brief interview mental status) of "9" out of a possible 15, or moderate cognitive impairment. Resident #18 was also coded as requiring extensive assistance of one to two staff members to

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perform activities of daily living (ADLs), but was totally dependent on staff for bathing.

A review of the clinical record was conducted on 2/1/17 at 9:00 a.m.

Review of the comprehensive care plan included a plan for Resident #4's risk for impaired skin integrity related to thin, fragile skin and need for assistance with ADLs.

Review of the nurses notes revealed a note that read:
"9/25/16 - A Reddish in color bruise noted to residents right arm. Measurements 3.0 cm (centimeters) x 2.5 cm. No c/o (complaint of) pain or discomfort. Left message for RP (Responsible Party) to return call. MD (Medical Doctor) made aware."

Review of a Weekly Skin Assessment dated 9/21/16 read, "Bruises to left arm and right hand" were observed. There was no mention of a bruise to the right arm.

On 2/1/17 at 10:30 a.m., a request was made for the investigation of Resident #18's bruise that was identified on 9/25/16. Admin. D provided a copy of a form entitled, "Skin Integrity Events --Bruise. Status: Closed." Information on this form included:
"a. Bruise to Right Arm 9/25/16.
b. Color of Bruise - Reddish.
c. Character of Bruise - No Swelling.
d. Pain at site - No pain.
e. Activity during Bruise Occurrence - Unknown.
f. Possible Contributing Factors - None of Above."

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On 2/1/17 at 11:15 a.m., during an end of day meeting, the administrator, DON and Admin. D were asked if an investigation of the bruise of unknown origin was conducted and if the injury of unknown origin was reported to the State Agency, Office of Licensure and Certification. Admin D. said she would follow-up.

Further review of the comprehensive care plan did not reveal any interventions to prevent bruising that were put in place around the time of the bruise to her right arm.

On 1/31/17 at 5:15 p.m., during an end of day meeting, the administrator, DON and Admin. D were asked again if the bruise/injury of unknown origin was investigated and reported to the State Agency Office of Licensure and Certification. Admin D stated, "We've given you everything on it."

The facility Abuse Prevention, Investigation and Reporting Policy read:
a. Under Investigation read, "The facility will investigate and report incidents or occurrences to the state survey and other interested agencies in accordance with federal and state regulations..."
b. Under Reporting/Response read, "The Administrator will report all alleged violations and all substantiated incidents to the state agency..... Allegations that have resulted in no serious harm to the resident may be reported within 24 hours".

Resident #18's bruise to her right arm was an injury of an unknown source, and therefore considered an alleged violation. There was no documentation of interviews with the resident, potential witnesses or staff.

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On 2/1/17 at 1:00 p.m., the administration was informed of the facility staff's failure to thoroughly investigate and immediately report to the OLC Resident #18's bruise of unknown origin. No additional information was provided.

3. For Resident #9, the facility did not report a bruise of unknown origin to the OLC.

Resident # 9 was admitted to the facility on 3/21/14. Diagnoses for Resident # 9 included but not limited to dementia, macular degeneration and glaucoma.

Resident #9's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 11/17/16 coded Resident #9 with a BIMS (brief interview of mental status) score of "0" out of a possible 15, or severe cognitive impairment. In addition, the Minimum Data Set coded Resident #9 as requiring extensive to total assistance with bathing, dressing and feeding.

On 1/13/17 at 8:25 AM, Resident #9 was observed in the dining room. She was clean and well groomed and was wearing protective arm sleeves on both arms.

Review of the clinical record revealed a nursing note dated 11/18/16 at 9:26 PM which read: "Bruise noted to left upper arm. Bruise approximately quarter size noted. No complaints voiced of pain and discomfort. Message left for RP (responsible party) to return call to facility."

On 2/1/17, the facility presented an "Investigation of bruises, skin tears, scratches or other skin

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F 225	Continued From page 9 injuries." The investigation conclusion dated 2/20/17 read as followed: "Fragility of skin and bruising tendencies, discourage resident from leaning in chair with arm below body and chair." The resident was unable to state what had happened as she was cognitively impaired. The cause of the bruise was unknown. On 2/1/17 at 11:45 AM, an interview was conducted with the abuse coordinator (Administration D). She stated, "It starts with the incident being reported, the nurse asseses the resident, we look at the prior 48 hours, the report is then given to the DON (director of nursing). If the behavior (hitting self, scratching) is not care planned, we report the incident to the state." She also stated, "We will train the nurses to send a FRI (facility reported incident) first, before an investigation." The facility Abuse Prevention, Investigation and Reporting Policy read: a. Under Investigation read, "The facility will investigate and report incidents or occurrences to the state survey and other interested agencies in accordance with federal and state regulations..." b. Under Reporting/Response read, "The Administrator will report all alleged violations and all substantiated incidents to the state agency..... Allegations that have resulted in no serious harm to the resident may be reported within 24 hours." On 2/1/17 at 11:15 AM, the DON and Administrator were notified of above findings.	F 225		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

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F 241	Continued From page 10 (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to provide a dignified living experience for two Residents (Residents' #6 and #7) in a survey sample of 18 Residents. 1. For Resident #6, CNA (certified nursing assistant) A was standing over her, feeding Resident #6) and an 8.5 by 11 inch yellow sign was on the back of her wheelchair, addressing some of her care; and 2. For Resident #7, CNA A standing over her, during the evening meal, encouraging her to eat. The findings included: 1. For Resident #6, CNA A was standing over her, while feeding Resident #6 and an 8.5 by 11 inch yellow sign was on the back of her wheelchair, addressing some of her care. Resident #6, a female, was admitted to the facility 10/3/13. Her diagnoses included intestinal obstruction, dementia, anorexia, cellulitis right lower limb, pneumonia, hypertension, hyperlipidemia, depression and hyperlipidemia. Resident #6's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/15/16 was coded as a quarterly assessment.	F 241	Criterion #1: Resident #6 and Resident #7 are being assisted with eating from a seated staff member at their side. All staff have been, and will continue to be, provided with a chair suitable to their needs in the performance of their assisting residents while eating. Resident #6 has had the sign removed from their wheelchair. Criterion #2: Standing: Residents on a nursing unit that require assistance in eating could potentially be served by/from a standing staff member, if insufficient chair/seating supply is not available. All staff that assist resident while eating their meals will sit at the dining table with their resident. Chairs will be provided to accommodate the number of staff assisting resident and any visitors or guests that attend the meal. Signs: Signs indicating specific resident care items or instructions have been removed from all wheelchairs.	

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Resident #6 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #6 was coded as needing extensive to total assistance with all of her activities of daily living including eating.

During initial tour of the facility 1/30/17 at 6:40 p.m., Resident #6 was observed sitting in a wheelchair in the dining room. Her back was to the window of the room. CNA A was standing between Resident #6 and Resident #7, feeding Resident #6 with a spoon. From 6:40 p.m. until leaving the unit at approximately 7 p.m., CNA A was observed standing in the same spot. She was continuing to feed Resident #6 and appeared to be encouraging Resident #7 to eat.

Additionally, a yellow 8.5 by 11 inch sign was attached to the back of Resident #6's wheelchair. The sign was easily visualized and stated:

"ATTENTION ALL STAFF MEMBERS

DURING ANY W/C (wheelchair) ASSISTED TRANSPORT BY ANY STAFF MEMBER PLEASE REMIND RESIDENT TO LIFT UP THEIR FEET, STAFF WILL NEED TO MONITOR RESIDENT'S FEET AT ALL TIMES DURING ANY W/C ASSISTED TRANSPORT. PLEASE ENSURE THAT THE RESIDENT'S FEET REMAIN ELEVATED DURING ANY W/C TRANSPORT FOR SAFETY TO THE RESIDENT'S LOWER EXTREMITIES."

CNA A was interviewed, 1/31/17 at 4:20 p.m. CNA A stated she was standing between Resident #6 and #7 as Resident #6 needs to be fed and Resident #7 needs encouragement to eat

Standing:
Staff involved with resident meal-service will be in-serviced by the Education Director and the Resident Social Services Director on dignity while assisting in eating, facility policy on staff-resident interactions, and the proper dining room experience for residents.
The unit-charge-nurse will monitor each meal for these levels and determine whether additional seating is required.
The unit-charge-nurse will inform the DON [or his/her designee], prior to mealtime and throughout the meal-time whether there was an insufficient amount of seating.
The dining services director [or his/her designee] will audit the dining areas each meal for proper seating levels.
The dining services director [or his/her designee] will alert Administration of insufficient seating.
Signs:
All resident directed, care cueing directed, or family directed signage will be placed in each resident's closet, unobservable from passers-by or the general public.
Responsible party or resident direct demands that certain signage be present and viewable – will be honored, care-planned, and reviewed at the appropriate intervals.
In-servicing on the privacy regulations pertaining to resident signage will be performed.

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as she "plays" with her food. CNA A stated a family member had entered the dining room and needed a chair to sit by their family member. CNA A stated "I gave them my chair as there were not enough chairs..."

CNA A also stated the sign was on the back of Resident #6's wheelchair to remind staff to ensure Resident #6 kept her feet up while being transported.

ADM B, the DON (director of nursing) stated 1/31/17 at 5:10 p.m., the staff should not stand while assisting Resident #6 and #7 to eat. ADM B also stated the sign was put on the back of the wheelchair to remind staff to have people put foot pedals on wheelchairs when Residents are being transported. ADM B said 2/1/17 at 11:13 a.m., Resident #6's wheelchair was a small wheelchair, as Resident #6 was small. ADM B stated she was not aware of where the foot pedals for the chair were. The sign was to remind staff to have Resident #6 keep her feet up while being transported, even though she was coded as having short and long term memory deficits.

"Fundamentals of Nursing, 7 th Edition, Potter-Perry, page 475," provides guidance, "A sense of dignity includes a person's positive self-regard, an ability to invest in and gain strength from one's own meaning in life, feeling valued by others, and how one is treated by caregivers. Nurses promote a client's self esteem and dignity by respecting him or her as a whole person with feelings, accomplishments, and passions independent of the illness experience...When caring for a client's bodily functions, show patience and respect, especially after the client becomes dependent."

Criterion #4:
Standing:
Each dining area with residents receiving assistance while eating will be subject to a weekly audit by an Inter-Disciplinary Team Member utilizing Dining Area Rounding Audit .
The Quality Assurance Committee will review the monthly findings of Dining Area Rounding Audits and any associated Action Plans devised from previous findings.
Signs:
The Quality Assurance Committee will review residents that maintain instructive signage. This listing will be kept by the Director of Resident Services. The Quarterly Care Plan meeting will serve as a review for each resident with instructive signage with resident, care-givers, and responsible parties – to determine efficacy and appropriateness for resident's on-going care-planning.

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ADM C, the Chief Executive Officer (CEO) of the facility, stated 1/31/17 at 5:10 p.m., there were plenty of chairs at the facility and was uncertain why CNA A felt she did not have a chair to sit in while assisting Residents' #6 and #7 with their dinners.

The administrator and ADM B were informed of the failure of the facility staff to provide a dignified living experience during the dinner meal and by not having a sign addressing Resident #6's care, 2/1/17 at 11:13 a.m.

2. For Resident #7, CNA A standing over her, during the evening meal, encouraging her to eat.

Resident #7, a female, was admitted to the facility 10/24/14. Her diagnoses included muscle weakness, Alzheimer's disease, dementia, major depressive disorder, anxiety, hypertension, atrial fibrillation, central pain syndrome, and dysphagia.

Resident #7's most recent MDS with an ARD of 1/9/17 was coded as an annual assessment. She was coded as having short and long term memory deficits and required assistance with making daily life decisions. She was also coded as requiring limited to total assistance of one staff member to perform her activities of daily living.

The administrator and ADM B were informed of the failure of the staff to provide a dignified living experience by staff standing over Resident #7 during her evening meal while encouraging her to eat, 1/31/17 at 5:10 p.m.

F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	

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F 309	Continued From page 14 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (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 observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to provide care and services to attain or maintain the highest practicable wellbeing for four Residents (Residents' #12, #13, #3 and #2) in a survey sample of 18 Residents. 1. For Resident #12, the facility staff failed to administer Prednisone (a steroid) per physician's order. The facility administered Prednisone 40 mg (milligram) daily for 15 days instead of 14 days per physician's order;	F 309	Criterion #1: Resident #12's prednisone course concluded and no new courses were administered in this fashion. Resident #13's Doxazosin has subsequently been administered per the physician's order. This medication is available in the facility's emergency supply and this is now known to the nursing staff. Resident #3's Calcitonin has subsequently been administered as ordered. It is stored in the unit medication refrigeration and this is now known to the nursing staff. Resident #2's Baclofen has been subsequently administered as ordered. Criterion #2: Any resident receiving medications could be at risk to experience a medication omission. All residents receiving medications from staff will be included in this plan of correction.	

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F 309	Continued From page 15	F 309	Criterion #3: Nursing staff will receive in-service training on proper administration of duration-based medications, including order entry basics in MatrixCare (the facility's electronic medical record software) and how to properly apply start and stop dates. A blank MAR will be kept at the nurses' station for reference. Orders for medications requiring refrigeration will be clarified to include the location of the cold storage. Nurses with medication administration responsibilities have access to these areas. The facility will complete a 100% audit of current medications requiring refrigeration and update orders to reflect storage location. Licensed nurses and supervisors will receive in-service training on the response expected when a medication is believed to be unavailable. The protocol will be changed to include immediate notification of the shift supervisor. The shift supervisors will also receive training and education on the proper process for them to promptly address medications believed to be unavailable. Licensed nurses will receive in-service training on medications that require refrigerated storage, and how to access them.	

2. For Resident #13, the facility staff failed to administer Doxazosin, a physician ordered medication for hypertension;

3. For Resident # 3, the facility staff failed to administer the medication, Calcitonin, as ordered by the physician; and

4. For Resident #2, the facility staff failed to administer Baclofen (for muscle spasms).

The findings included:

1. For Resident #12, the facility staff failed to administer Prednisone (a steroid) per physician's order. The facility administered Prednisone 40 mg (milligram) daily for 15 days instead of 14 days per physician's order.

Resident #12, a female, was admitted to the facility 3/2/15. Her diagnoses included abnormal posture, constipation, shortness of breath, senile degeneration, asthma, hydronephrosis, other malaise, altered mental status, intestinal obstruction, nausea, displaced fracture, kyphosis, depression, cellulitis, insomnia, type II diabetes mellitus, anxiety, dementia, macular degeneration, and Crohn's disease.

Resident #12's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/19/17 was coded as a quarterly, five day assessment. She was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #12 was coded as needing limited to extensive assistance of one staff member to perform all of her activities of daily living with the

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exception of bathing. For bathing she was coded as needing total assistance.

Resident #12 was observed 2/1/17 at 8:14 p.m. She was lying on her back in bed, having just receiving morning care. She was alert, however very confused.

Review of Resident #12's clinical record revealed she had been hospitalized and returned to the facility 1/13/17. Included within her readmission orders was, "1/14/17 Prednisone 10 mg amount: 40 mg Special Instructions Take 4 tabs (40 mg) po (by mouth) daily with breakfast for 2 weeks." An accompanying entry was placed on the eMAR (electronic medication administration record) with nurses' initials indicating Prednisone 40 mg was administered daily from 1/14/17 through 1/28/17 (15 days).

A thorough review of Resident #12's clinical record failed to reveal any clinician's order changing the administration of Prednisone 40 mg to 15 days instead of 14 days.

When interviewed 2/1/17 at 9:10 a.m., the DON (director of nursing) stated she would review the clinical record to determine how 15 days of Prednisone 40 mg were administered to Resident #12 instead of the physician ordered 14 days.

The nurse that administered the medication on 1/28/17 (the 15th day) stated 2/1/17 at 12:50 p.m., the medication came up on the computer program to be administered, "So I gave it..."

The DON (director of nursing) stated 2/1/17 at 12:50 p.m., the nurse that entered the order into the eMAR system, entered it incorrectly. The

The nursing supervisor will be given the training and capability to run a medication pass compliance report each day, mid-shift and will address findings to the charge nurse immediately for remedy. The supervisor will also compile a per shift report of any medications that are omitted or late due to availability issues. These reports will be reviewed weekly by the Qa Nurse or designee and summarized in a quarterly report to the Qa Committee, to evaluate the effectiveness of this POC.

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DON said the nurse entered for the medication to be administered 1/14 to 1/28/17 (15 days). The DON stated the nurse should have entered for the medication to be administered for 14 days instead of entering actual dates.

Review of the facility's policy entitled "General Dose Preparation and Medication Administration" included:

"4.1 Facility staff should:

4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set for in Appendix 17...
4.1.2 Confirm that the MAR reflects the most recent medication order;"

www.drugs.com provides guidance for the administration of Prednisone:

"Prednisone is a corticosteroid. It prevents the release of substances in the body that cause inflammation. It also suppresses the immune system.
Prednisone is used as an anti-inflammatory or an immunosuppressant medication. Prednisone treats many different conditions such as allergic disorders, skin conditions, ulcerative colitis <https://www.drugs.com/mcd/ulcerative-colitis>, arthritis <//www.drugs.com/arthritis.html>, lupus, psoriasis <//www.drugs.com/condition/psoriasis.html>, or breathing disorders.

Take prednisone exactly as prescribed by your doctor. Follow all directions on your prescription

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label. Your doctor may occasionally change your dose to make sure you get the best results. Do not take this medicine in larger or smaller amounts or for longer than recommended." Guidance for administration of medications was provided in "Potter Perry Fundamentals of Nursing 7th Edition, page 706, Responsibility and accountability are other critical thinking attitudes essential to safe medication administration. Accept full accountability and responsibility for all action surrounding the administration of medications. When administering medications to a client, do not assume that the medication that is ordered for the client is the correct medication or the correct dose. Be responsible for knowing that the medication ordered for clients are the correct medications and the correct doses. You are responsible for administering an ordered medication that is knowingly inappropriate."
The administrator and DON were informed of the failure of the staff to administer Prednisone 40 mg for 14 days per physician's order, 2/1/17 at 11:10 a.m. The facility staff administered Prednisone 40 mg for 15 days instead of the physician ordered 14 days.
2. For Resident #13, the facility staff failed to administer Doxazosin on 1/23/17, a physician ordered medication for hypertension.

Resident #13 was admitted to the facility on 1/23/2017 at 4:30 p.m. with the diagnoses of, but not limited to, diabetes, stroke, constipation, arthritis, end stage renal disease, dialysis on Monday, Wednesday and Friday and hypertension.

The most recent MDS (Minimum Data Set) was an entry assessment with an ARD (Assessment Reference Date) of 1/23/17. Review of the

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admission nursing assessments revealed Resident #13 was alert and oriented, able to express her needs and required limited assistance from staff for her activities of daily living (ADLs).

On 1/30/17 at 6:45 p.m., Resident #13 was observed in her room seated beside her bed and focused on using her laptop which was on her bedside table. Resident #13 was interviewed at this time and stated, "I have been to three other facilities, and this one is by far the best." On 2/1/17 at 9:00 a..m., Resident #13 was out of the facility for scheduled dialysis.

On 2/1/17 at 9:15 a.m., Resident #13's clinical record was reviewed. The review revealed admission physician orders dated 1/23/17 for Doxazosin 2 mg (milligram) at bedtime for hypertension.

"Doxazosin is an alpha-adrenergic blockers. It relaxes your veins and arteries so that blood can more easily pass through them." drugs.com

Review of the Medication Administration Record (MAR) with a start date of 1/23/17 revealed the Doxazosin was not documented as having been administered at 9:00 p.m. on 1/23/17. Under Reasons/Comment read, "Not Administered: Drug/Item Unavailable."

On 2/1/17 at 10:36 a .m., an interview was conducted with LPN (licensed practical nurse) D, regarding the Doxazosin that was not administered per physician order on 1/25/17. LPN D said she would look into the matter and follow-up.

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On 2/1/17 at 11:15 a.m., the DON (Director of Nursing) provided follow-up information about the Doxazosin that was documented as not having been administered on 1/23/17. The DON stated, "The medication was not administered, but it was available for administration from our emergency supply." The DON provided a list of the emergency medication inventory which included a quantity of 10 - 2 mg tablets of Doxazosin that was available for administration.

On 2/1/17 at 1:45 p.m., Admin D cited Potter and Perry, Fundamentals of Nursing, Eight Edition, as the facility's reference for professional nursing standards.

Guidance given from Potter and Perry, Fundamentals of Nursing, Eighth Edition, page 305 read: "Nurses follow health care providers orders unless they believe the orders are in error or harm patients."
On 2/1/2017 at approximately 1:00 p.m., the Administrator and Director of Nursing were informed of the findings. The facility staff did not present any additional information regarding the findings.

3. For Resident #3, the facility staff failed to administer the medication, Calcitonin, as ordered by the physician.

Resident #3 was an 87 year old female admitted to the facility on 9/3/2016 with the diagnoses of, but not limited to, Right Femoral Head Fracture, Chronic Pain Syndrome, Congestive Heart Failure, Atrial Fibrillation, Dysphagia, Chronic Obstructive Pulmonary Disease, Hypothyroidism, and chronic indwelling catheter.

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The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/5/16. The MDS coded Resident #3 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; Resident #3 required limited assistance of two staff persons with activities of daily living except supervision of set up only for eating; also coded as always incontinent of bowel and an indwelling catheter for bladder.

On 1/312016 at 9:30 AM, review of the clinical record was conducted.

Review of the Medication Administration Record (MAR) for January 2017 revealed documentation of a medication, Calcitonin (salmon) spray, non-aerosol; 200 unit/actuation; Amount to administer: 1 spray; nasal as being "not administered; drug/item unavailable" on 1/15/2017 at 10:00 AM.

On 1/31/2017 at 1:35 PM, an interview was conducted with the Quality Assurance Nurse, LPN D (Licensed Practical Nurse D) who stated that nurses were expected to administer medications as ordered by the physician.

On 2/1/2017 at 9:35 AM, the Director of Nursing (DON)stated she was sure the medication was available for administration. The DON stated the nurses have a "Shift Report form" where they are expected to list any medications unavailable. The DON stated the form was utilized to inform the supervisors of any problems to include any medications that were unavailable. The DON stated the supervisor would direct the nurses of the next steps to take if a medication was not available.

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On 2/1/2017 at 10:00 AM, the DON presented a copy of the shift report from 1/15/2017 which revealed there were no medications listed as unavailable on the 7-3 cart on Unit 1 on which Resident #3 resided. The DON stated the medication was available in the refrigerator and the nurse should have administered the medication.

On 2/1/2017 at 11:00 AM, the DON presented a copy of the Pharmacy Shipment which revealed a bottle of the medication, Calcitonin-Salmon 200 unit/1 dose Spray/pump had been delivered for Resident #8 on 1/9/2017. The DON stated the nurse who was supposed to have administered the medication on 1/15/2017 would be counseled and educated on the proper procedures for administering medications along with how to notify the supervisor if a medication was unavailable for administration.

During the end of day debriefing on 2/1/2017 at 11:15 AM, the Administrator and Director of Nursing were informed of the findings.

No further information was provided.

4. For Resident #2, the facility staff failed to administer Baclofen (for muscle spasms).

Resident #2, a 77 year old, was admitted to the facility on 3/20/13. His diagnoses included Guillain-Barre syndrome, dysphagia, peripheral vascular disease, hemipeligia, and hypertension.

Resident #2's most recent Minimum Data Set assessment was a quarterly assessment with an

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(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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assessment reference date of 1/4/17. He was coded to have moderate cognitive independence and required extensive assistance with activities of daily living.

Resident #2 had a physician order dated 9/25/16 for Baclofen 5 milliliters (ml) four times per day for muscle spasms.

The January 2017 Medication Administration Record (MAR) was reviewed. Included was an entry for Baclofen 5 ml four times per day. It was documented on the MAR that the 9:00 a.m. dose on 1/14/17 was "Not Administered: Drug/ Item unavailable."

During the end of day meeting on 1/31/17, the Director of Nursing (DON) was asked to look into the issue regarding the unavailable medication. On 2/1/17 at 9:35 a.m., the DON stated that the medication had been available and should have been administered. She stated that the Baclofen was in the refrigerator and available for administration on 1/14/17.

The issue with the Baclofen was reviewed again at the end of day meeting on 2/1/17. No further information was provided.

F 314 SS=D — 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES — F 314

(b) Skin Integrity -

(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-

(i) A resident receives care, consistent with

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F 314	Continued From page 24 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to assess and track a pressure injury for one Resident (Resident #6) in a survey sample of 18 Residents. After the initial identification of a Stage II pressure injury, developed by Resident #7, the facility staff failed to assess or track the area. www.npuap.com defines a Stage II pressure injury: "Stage II: Partial-thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Further description: Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation. *Bruising indicates suspected deep tissue injury" The findings included:	F 314	Criterion 1 Resident # 6: As noted in the deficiency, the facility's Wound Nurse (LPN E) acknowledged that the detailed documentation of her assessment of this pressure area was not included in the record between discovery on 11/18/16 and healing on 12/12/16. Correction for this individual resident record is not possible. The resident's pressure area did heal on 12/12 as noted, and has not recurred. Criterion 2 All residents who are assessed with pressure areas are potentially at risk for omissions in weekly progress assessment. Weekly progress documentation will be reviewed for the period of 11/1/16 through 1/31/17 to identify residents who may have been affected.	

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Resident #6, a female, was admitted to the facility 10/3/13. Her diagnoses included intestinal obstruction, dementia, anorexia, cellulitis right lower limb, pneumonia, hypertension, depression and hyperlipidemia.

Resident #6's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/15/16 was coded as a quarterly assessment. Resident #6 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #6 was coded as needing extensive to total assistance with all of her activities of daily living including eating. Resident #6 was coded as having a Stage II pressure injury that was diagnosed on 11/18/16.

Resident #6 was observed 1/30/17 at 6:40 p.m. She was out of bed and in her wheelchair, being fed her dinner in the unit dining room. Resident #6 was also observed 1/31/17 at 8:10 a.m. Again she was out of bed and in her wheelchair in the dining room. Resident #6 was alert and softly verbally responsive. She was confused to place and time.

Resident #6's pressure injury was unable to be observed as it had healed six weeks prior. Observation of her skin revealed no pressure injury was present at the time of the survey.

Review of Resident #6's clinical record revealed within the interdisciplinary notes, an entry that indicated a Stage II pressure injury was identified on Resident #6's right medial intergluteal fold. The physician and responsible party were notified and treatment was ordered, "11/18/16 Cleanse stage 2 pressure ulcer to right buttock NS

The facility believes that the omission of the specific electronic assessments correlated with dates when the Wound Nurse (LPN E) was on leave from the facility, and a lack of communication to her coverage as to which specific assessments were due on these dates. To correct this issue, the facility will:

1) Appoint a designated relief Wound Nurse, who will be thoroughly trained in our facility's protocol and expectations for weekly wound documentation

2) Provide a weekly listing to the Director of Nursing of each resident with a new or continuing pressure area, to ensure that an accurate assignment is provided to the relief nurse if and when she assumes responsibility in the absence of the Wound Nurse.

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(normal saline), Pat dry apply Greee's (sp) Goo Daily." Greer's Goo is a combination of nystatin powder, hydrocortisone powder, and zinc oxide paste. It is used to treat intertrigo (inflammation of the body folds), diaper rash, etc.

Review of the TAR (treatment administration record) revealed the treatment was administered until 12/19/16 when a physician's order was obtained to discontinue the treatment.

A thorough review of Resident #6's clinical record revealed that other than the interdisciplinary note entered on 11/18/16 upon discovery of the area, only one other nursing note was evident describing the area. That note was 12/15/16 that indicated the area was healed. Within the initial note, no documentation was evident of the size, description, wound bed assessment, assessment of pain, edema, or drainage from the area.

Review of the electronic record revealed no wound assessment had been done upon discovery of the area, nor during the time the Stage II was being treated. Weekly skin assessments were evident within the clinical record however the only documentation about the area in Resident #6's intergluteal fold was notations of "treatment in progress." A thorough review of the electronic and paper clinical record revealed no assessment nor tracking were completed for the Stage II pressure area.

LPN (licensed practical nurse) E, the wound care nurse, was interviewed 1/31/17. LPN E stated that upon discovery of a wound or pressure injury, the floor staff were to assess the area. The floor staff were to notify the physician and obtain a treatment order, notify the wound care nurse

The completion of the weekly progress assessments will be monitored by the QA Nurse or designee, who will review the electronic assessments once per week against the weekly listing of residents with pressure areas to ensure that all assessments have been thoroughly completed. The QA nurse will provide a copy of her audit to the Wound Nurse for any action required.
The QA Nurse will provide a monthly report to the facility's QA Committee in order to evaluate the effectiveness of this plan, and make any recommendations to enhance compliance.

Completion Date: March 2, 2017

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(LPN E) and notify the responsible party. LPN E stated she would then assess the area and determine if the treatment was appropriate. LPN E stated the facility had a tracking system for wounds and pressure injury and that she was responsible for completing the tracking system.

LPN E stated she had reviewed the electronic record and did not see that the wound care tracking had been completed. While the floor nurses completed the daily pressure ulcer and wound care, LPN E stated she was supposed to assess and measure the areas weekly, documenting in the wound care tracking system in the electronic clinical record. LPN E presented what she identified as her tracking notes for the time that Resident #6 was known to have a Stage II pressure injury.

The paper was titled as "Weekly Summary of Pressure Areas" and included:

"Date 12/5-12/8/16 (R) (right) buttock Stage II improving

Date 12/12-12/15/16 (R) buttock healed

Date 12/19-22/16 (R) buttock healed"

No evidence of the size of the area, description, wound base, edema, pain, or drainage was apparent within the paper tracking.

When interviewed, LPN E stated she was unaware that she had not completed the electronic tracking for Resident #6's pressure injury. She stated the paper tracking form was for her information, however she was unable to determine why the tracking did not include

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particulars related to Resident #6's pressure injury such as size, description, drainage, etc.

Review of the facility's policy entitled "Pressure Ulcer Prevention and Treatment" included:

"PROCEDURE

Critical steps in pressure ulcer prevention and healing include: assessment (identifying the individual resident at risk for developing pressure ulcers, assessing the individual risk factors, identifying and evaluating factors that can be removed or modified), implementing individualized interventions to attempt to stabilize, reduce or remove underlying risk factors, monitoring the impact of the interventions, and evaluation-modifying the interventions as appropriate.

ULCER CHARACTERISTICS

1. ESSENTIAL DOCUMENTATION OF PRESSURE ULCERS-when a pressure ulcer is present, documentation will be done by the Wound Nurse and will include:

a. Location and staging;

b. Size (perpendicular measurements of the greatest extent of length and width of the ulceration), depth; and the presence, location and extent of any undermining or tunneling/sinus tract;

c. Exudate (drainage), if present: type (such as purulent/serous), color, odor and approximate amount;

d. Pain, if present: nature and frequency (e.g. whether episodic or continuous);

e. Wound bed: Color and type of tissue/character including evidence of healing

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(e.g. granulation tissue), or necrosis (slough or eschar); and

f. Description of wound edges and surrounding tissue (e.g. rolled edges, redness, hardness/induration, maceration) as appropriate.

3. THE HEALING PRESSURE ULCER Ongoing evaluation and research have indicated that pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g. muscle, fat and dermis) that were lost during the pressure ulcer development, and the facility does not "reverse stage" pressure ulcers as they heal...

a. The wound nurse will document the healing progress of each pressure ulcer at least weekly."

Guidance was provided in "Pressure Ulcer Treatment Department of Health and Human Services page 6

ASSESSMENT

Assessment is the starting point in preparing to treat or manage an individual with a pressure ulcer. Assessment involves the entire person, not just the ulcer, and is the basis for planning treatment and evaluating its effects. Adequate assessment is also essential for communication among caregivers...

Initial assessment. Assess the pressure ulcer(s) initially for location, stage, size, (length, width, and depth), sinus tracts, undermining, tunneling, exudate, necrotic tissue, and the presence or absence of granulation tissue and epithelization...

Reassessment. Reassess pressure ulcers at

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F 314	Continued From page 30 least weekly...If the condition of the patient or wound deteriorates, reevaluate the treatment plan as soon as any evidence of deterioration is noted. Monitoring progress. A clean pressure ulcer with adequate innervation and blood supply should show evidence of some healing within 2 to 4 weeks. If no progress can be demonstrated, reevaluate the adequacy of the overall treatment plan as well as adherence to this plan, making modifications as necessary." The administrator and DON (director of nursing) were informed of the failure of the staff to assess and track Resident #6's pressure injury identified on 11/18/16 and healed by 12/15/16, 1/31/17 at 5:10 p.m.	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (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.	F 323	Criterion 1 The bottle of Baclofen was removed from the top of the medication cart following the surveyor's observation. Resident #11's bed alarm was discontinued on 1/31/17. The resident has been sleeping through the night, and although the chair alarm remains effective during the day when he is up in his chair, the bed alarm was assessed as unnecessary. Criterion 2 All residents are potentially affected by the facility's practices in securing medications and preventing accidental or intentional ingestion. Residents who have alarms ordered as part of their fall prevention program are potentially at risk if alarms are not properly placed; all residents with orders for bed alarms will be identified and addressed through this plan of correction.	

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(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:
Trevilian, Rose
Based on observation, staff interview and clinical record review, the facility staff failed to ensure a safe living environment and failed to ensure a physician ordered bed alarm was in place for one resident, (Resident #11) in a survey sample of 18 residents.

A full bottle of Baclofen (medication used to treat muscle spasms) was left on top of the medication cart out of sight of the nurse and a bed alarm was not in place for Resident #11.

The findings included:

On 1/30/17 at approximately 6:30 PM, during the initial tour, a full bottle of Baclofen was left on top of the medication cart, which was out of sight of any nurse. No residents were near the medication cart at this time.

Resident # 11 was admitted to the facility on 3/23/16. Diagnoses for Resident #11 included but not limited to dementia with behavior disturbance, Parkinson's disease and anxiety.

Resident #11's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 12/8/16 coded Resident #11 with a BIMS (brief interview of mental status)

Criterion 3
Medication Supervision
Licensed nurses with medication administration responsibilities have received remedial in-service training regarding the necessity to secure any medications when not under direct supervision.
The facility medication carts have adequate room for storing bottles of liquid medications. Proper storage was reviewed and the medication carts will be inspected each week to ensure that storage is not an issue.
Each shift, the nursing supervisor (or DON designee on day shift) will be required to make rounds on each unit, between medication passes and enforce facility policy regarding storage of medications in the cart and not on top of the cart. The supervisor or designee will note on the daily shift report any observation that a nurse has left a medication on top of a cart, and the action taken with the nurse.
Bed Alarms
Nursing staff will be re-educated in the appropriate use of bed alarms, the necessity for frequent validation of placement and ongoing resident assessment of need.
On a daily basis, a hard copy list of residents with alarms in place will be generated by the night shift supervisor. The list will be used by the Administrator in assigning a department head to make daily rounds on all residents who have alarms. The purpose of the rounds will be to validate that these devices are being used where ordered and documented accurately by the staff. The reviewer will be required to identify and document any variances on the list and report these immediately to

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score of "7" out of a possible 15, or moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #11 as requiring extensive assistance of one staff member for feeding, bathing, ambulation and dressing. No falls were coded in the last 90 days.

On 1/31/17 at 11:25 AM, Resident #11 was observed in the bed with his eyes closed. His catheter was placed in a privacy cover. There was no bed alarm evident. There was a chair alarm in place on the wheelchair.

On 1/31/17 at 2:55 PM, Resident #11 was observed in the bed. LPN (licensed practical nurse) A accompanied writer to the resident's room by request. LPN (A) agreed there was no bed alarm in place. LPN (A) stated, "He has an active order." LPN (A) called medical supply in house for a pad alarm for the bed.

On 2/1/17 at 8:50 AM, Resident #11 was again observed in the bed. There was no bed alarm in place. The charge nurse stated that the order for the bed alarm was discontinued; the chart was checked and the order was entered to discontinue the bed alarm on 1/31/17.

Review of the care plan dated 12/3/16 revealed the following: "Resident at risk for falls related to dementia, Parkinson's and impaired mobility." There was an intervention dated 12/3/16 for "Resident has a bed alarm to alert staff of rising pattern. Check for proper placement and functioning daily."

Review of the treatment record for January, 2017, included the following order dated 10/14/16: "Bed alarm, check every shift." The order was signed the nurse in charge.

Criterion 4
Medication Supervision
Compliance with safe medication storage will be monitored by the DON. On a weekly basis, the Director of Nursing (or her designee) will make unannounced rounds of all medication carts and document any findings of non-compliance with safe storage. The DON will apply appropriate remedial action upon an observation that medication has been left unattended on top of a medication cart. The results of these weekly audits will be summarized in a report to the Quality Assurance Committee; the Committee is responsible to evaluate the effectiveness of this plan of correction and recommend any additional actions required to maintain compliance.
Bed Alarms
The results of the daily audits by department heads will be tabulated by the Administrator at the end of each week in order to monitor staff compliance with application of bed alarms. On a monthly basis, the Administrator will provide a report to the QA Committee; the report will include but is not limited to: the number of bed alarms in use, the number of bed alarms that were checked and found not properly placed, and any residents for whom an alarm reduction should be considered due to reduced benefit or lack of indication. The Committee will review staff compliance with alarm placement and assess the effectiveness of this plan of correction.

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F 323	Continued From page 33 as completed for all the days of January, 2017, including 1/31/17 for the 7-3 shift. On 2/1/17 at 11:45 AM, the DON (director of nursing) and the Administrator were notified of the above findings.	F 323		
F 386 SS=D	483.30(b)(1)-(3) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS (b) Physician Visits The physician must-- (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; (2) Write, sign, and date progress notes at each visit; and (3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the clinician signed and dated all orders with each visit for two Residents (Residents #6 and #7) in a survey sample of 18 Residents. 1. For Resident #6, the facility staff failed to ensure the clinician reviewed and approved the recapitulation of treatments, medications, and the plan of care since 11/22/16 (70 days); and 2. For Resident #7, the facility staff failed to ensure the clinician reviewed and approved the	F 386	Criterion 1 Resident #6 The attending physician has been notified that he did not evidence review and approval of his plan of care when he visited the resident on 1/12/17. He has made arrangements to visit the resident again before the next scheduled visit, for the purpose of reviewing and signing the total program of care, including medications and treatments. Resident #7 The attending physician has been notified that he did not evidence review and approval of his plan of care when he visited the resident on 1/12/17. He has made arrangements to visit the resident again before the next scheduled visit, for the purpose of reviewing and signing the total program of care, including medications and treatments.	

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recapitulation of medications, treatments and the plan of care since 1/22/16 (70 days).

The findings included:

1. For Resident #6, the facility staff failed to ensure the clinician reviewed and approved the recapitulation of treatments, medications, and the plan of care since 11/22/16 (70 days).

Resident #6, a female, was admitted to the facility 10/3/13. Her diagnoses included intestinal obstruction, dementia, anorexia, cellulitis right lower limb, pneumonia, hypertension, hyperlipidemia, depression, and hyperlipidemia.

Resident #6's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/15/16 was coded as a quarterly assessment. Resident #6 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #6 was coded as needing extensive to total assistance with all of her activities of daily living including eating.

Review of Resident #6's clinical record revealed no evidence the clinician had reviewed and approved the recapitulation of treatments, medications, and total plan of care since 11/22/16. An electronic progress note was evident that Resident #6 had been evaluated and had a physical assessment on 1/12/17 by her physician.

LPN (licensed practical nurse) D, stated 1/31/17 at 2:11 p.m., when the clinical record was moved to an electronic record, the physician's were to review and approve the plan of care, including

The review of the total plan of care is required for all residents when they are visited by their physician at the required intervals, and all residents are included in the plan of correction.

Criterion 3
Physicians are required to document their review of the total program of care at each required visit, and the facility software provides a specific method for them to easily do this. In reviewing this deficiency, both residents are assigned to the same physician, who will receive individual instruction from the facility QA nurse on how to document his review in a timely and appropriate manner. All physicians attending at Beth Sholom received written description of the deficiency and notification that documenting their review at visit is a regulatory requirement and our expectation.

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medications and treatments when they wrote their 30 or 60 day progress notes. Upon reviewing the note completed by Resident #6's physician on 1/12/17, LPN D said the physician did not complete his note. LPN D further stated the physician should have included the review and approval of the plan of care in the electronic progress note.

The administrator and DON (director of nursing) were informed of the failure of the staff to ensure Resident #6's clinician reviewed and approved the recapitulation of the plan of care including medications and treatments with his progress note for the 1/12/17 visit, 2/1/17 at 11:15 a.m.

2. For Resident #7, the facility staff failed to ensure the clinician reviewed and approved the recapitulation of medications, treatments and the plan of care since 11/22/16 (70 days).

Resident #7, a female, was admitted to the facility 10/24/14. Her diagnoses included muscle weakness, Alzheimer's disease, dementia, major depressive disorder, anxiety, hypertension, atrial fibrillation, central pain syndrome and dysphagia.

Resident #7's most recent MDS with an ARD of 1/9/17 was coded as an annual assessment. She was coded as having short and long term memory deficits and required assistance with making daily life decisions. She was also coded as requiring limited to total assistance of one staff member to perform her activities of daily living.

Review of Resident #7's clinical record revealed she was assessed and examined by her physician 1/12/17. Documentation within the progress note, completed by the physician on

The Quality Assurance Nurse (QA Nurse or designee) will be responsible for monitoring physician compliance with the review of the plan of care. The nurse will use the monthly visit schedule to check behind each physician to validate that the plan has been reviewed, and a signature is present. The QA Nurse will provide a summary of her findings, including any variances, to the Quality Assurance Committee (which includes the Medical Director). Non-compliant physicians will be subject to restriction of their practice at Beth Sholom.

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F 386	Continued From page 36 1/12/17 revealed he did not review nor approve Resident #7's plan of care including medications and treatments. The last review and approval of the plan of care was documented as having been completed by the nurse practitioner during her visit with Resident #7, 11/22/16. The administrator and DON were informed of the failure of the staff to ensure the clinician reviewed and approved the plan of care during his visit with Resident #7 1/12/17, 2/1/17 at 11:15 a.m.	F 386		
F 387 SS=D	483.30(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure one Resident (Resident #8) in a survey sample of 18 Residents, was seen and evaluated by her clinician in a timely manner. For Resident # 8, the facility staff failed to ensure physicians visits were timely. Resident # 8 was not seen by the physician between 10/3/2016 and 12/29/2016 resulting in 86 days between visits. The findings included:	F 387	Criterion 1 The physician who is attending resident #8 was informed that his last visit (12/29/16) was not timely and has been advised of this plan of correction. He is scheduled to see resident #8 on or before 2/27/17 and has assured the facility that the visit will be in compliance with required timeframes. Criterion 2 All residents are required to be seen by a physician at least every 30 days for the first 90, and 60 days thereafter, and all are included in this plan of correction. Criterion 3 A letter has been sent to each physician who attends to residents at Beth Sholom Home, advising them of the need for compliance with visit requirements, and facility policy. Beth Sholom is prepared to revoke the privileges of any physician who cannot consistently maintain timeframes and this information was included in the letter.	

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Resident # 8, a female, was admitted to the facility 4/10/2012. Her diagnoses included but were not limited to: Hypertension, Parkinson's Disease, Tardive Dyskinesia, Depression, Hypothyroidism, Degenerative Joint Disease of the Knees, Pseudobulbar Affective Disorder and Pacemaker.

Resident # 8's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/12/2016 was coded as a Quarterly assessment. She was coded as having a BIMS of 12 indicating moderate cognitive impairment. Resident # 8 was coded as requiring limited to total assistance of one to two staff members for activities of daily living except supervision for eating. Resident # 8 was coded as being always incontinent of bowel and bladder.

Review of Resident # 8's clinical record was conducted on 1/31/2017 at 2:45 PM. Review of the Physicians Progress notes revealed the last signed progress note sheet was 12/29/2016 for "60 day visit." Review revealed Resident # 8 was seen by her physician on 10/4/2016 for a "60 day visit." A thorough review of her clinical record revealed a clinician's visit by the nurse practitioner was made on 10/17/2016 for a sick visit for diagnosis of congestion. There were no other visits documented in the clinical record between 10/4/2016 and 12/29/2016 resulting in 86 days between physician visits.

On 1/31/2017 at 4:10 PM, LPN (licensed practical nurse) D, the Quality Assurance Nurse, stated she would check to see if any other visits were documented. LPN D stated the expectation was that the physician should have timely visits at least every 60 days.

Each month, the Quality Assurance Nurse (or designee) will provide a list to each attending physician, identifying to them when their visits are due. She will keep a copy of this list for monitoring compliance and for notifying any physician that does not document a visit by the established due date.

Criterion 4
The Quality Assurance Nurse (or designee)will generate a weekly report from our facility's software program to identify which visits have taken place and which have not and to act upon variances. She will be responsible to monitor physician compliance and to report on the effectiveness of this plan of correction to the QA Committee.

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F 387	Continued From page 38 On 2/1/2017 at 10 AM, the DON (Director of Nursing) stated no other clinician visits had been made by Resident # 8's physician during the October - December 2016. The DON stated the expectation was that the physician should have timely visits at least every 60 days. During the end of day debriefing on 2/1/2017 at approximately 11:10 a.m., the administrator and DON were informed of the failure of the staff to ensure Resident # 8 was seen by her clinician at least every 60 days. No further information was provided.	F 387		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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. (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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient	F 431	Criterion 1 The vial of PPD (purified protein derivative) was discarded after the finding by the surveyor. It was found that a box of medication prevented the lock from latching. Criterion 2 All residents are potentially affected by facility practices in drug storage, and all areas of drug storage are included in this plan of correction.	

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F 431	Continued From page 39 detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted 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 documentation review, the facility staff failed to ensure biologicals and medications were stored appropriately on two of four units. 1. On Unit 3, PPD (purified protein derivative) dated as opened 12/21/16 was available for	F 431	Criterion 3 Licensed nursing staff will receive remedial in-service training that addresses the issues cited in this deficiency. The in-service training includes a review of facility policy to date each vial at the time that it is opened, to apply the date on the bottle / vial label (vs. box), and to discard the vial according to the manufacturer's instructions that address shelf life. Nurses were also advised to consult with the facility pharmacy whenever dating and destruction questions arise. The in-service training also include a review of Federal regulations that require storage of controlled substances under double lock, and appropriate and immediate actions to take when one layer of security is not available or malfunctions. In-service instruction included the need to double-check the drawer for obstructions. **Completion Date: March 2, 2017**	

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administration to Residents. PPD is only good for 30 days after opened and accessed;

2. On Unit 4, liquid and injectable Lorazepam was not stored with a double lock.

The findings included:

1. On Unit 3, PPD (purified protein derivative) dated as opened 12/21/16 was available for administration to Residents. PPD is only good for 30 days after opened and accessed.

The medication room for Unit 3 was observed 2/1/17 at 10:56 a.m. Located within the medication refrigerator was one vial of opened and accessed PPD. The vial was dated as having been opened and accessed 12/21/16 (41 days prior to the observation).

PPD is a solution that is utilized to test Residents and staff for exposure to tuberculosis.

When interviewed concerning the liquid and injectable PPD, LPN (licensed practical nurse) C stated at the time of the observation, the PPD was only "good" for use for 30 days after being opened and accessed. LPN C referred to guidance provided to the facility:

"Store in refrigerator at 36 degrees-46 degree F (Fahrenheit) (2 degrees-8 degrees C-centigrade). Protect from light. Date when opened and discard unused portion after 30 days."

Guidance was also provided at www.fda.gov:

"Vials in use for more than 30 days should be

The Director of Nursing or designee will be responsible to conduct an unannounced, weekly review of all medication storage areas, including an inspection of medication vials or bottles for proper dating and to verify that all controlled substances are stored under functional, double locks.
The results of the weekly audits will be summarized in a report to the Quality Assurance Committee; the Committee is responsible to evaluate the effectiveness of this plan of correction and recommend any additional actions required to maintain compliance.

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discarded."

The administrator and DON (director of nursing) were informed of the failure of the staff to ensure PPD was not available for use after 30 days of being opened and accessed, 2/1/17 at 11:50 a.m.

2. On Unit 4, liquid and injectable Lorazepam was not stored in the medication refrigerator with a double lock.

The medication room on Unit 4 was observed 2/1/17 at 10:42 a.m. When the medication room was entered LPN B unlocked and opened the door to the room. Located within the room was a medication refrigerator. There was no lock on the refrigerator door and the medication refrigerator was easily opened. A container was observed that slid into a drawer system on one of the shelves of the refrigerator. While a locking mechanism was noted on the exterior the container, the container was easily slid out of the drawer and removed from the refrigerator.

Located within the drawer were four bottles of liquid Lorazepam and five vials of injectable Lorazepam.

Guidance for administration and storage of Lorazepam was provided at www.medlineplus.gov:

Lorazepam is used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation.

also, www.drugs.com:

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"The use of benzodiazepines, including Lorazepam, may lead to physical and psychological dependence. The risk of dependence increases with higher doses and longer term use and is further increased in patients with a history of alcoholism or drug abuse or in patients with significant personality disorders. "

When interviewed, LPN B stated the drawer in the refrigerator with the Lorazepam should be locked at all times.

Review of the facility policy entitled "Recommended Minimum Medication Storage Parameters" included:

"Store in refrigerator and in accordance with State and Federal regulation for Schedule IV Controlled Substances..."

The administrator and DON were informed of the failure of the staff to ensure liquid and injectable Lorazepam (a Schedule IV medication) was stored in the medication room and refrigerator with a double lock, 2/1/17 at 11:50 a.m.