PRINTED 03/02/2017
FORM APPROVED
OMB NO 0938-0391

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
	495252	A. BUILDING _____ B. WING _____	C 02/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-BATTLEFIELD PARK	250 FLANK ROAD PETERSBURG, VA 23805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 000 INITIAL COMMENTS

An unannounced Medicare/Medicaid standard survey was conducted 2/13/17 through 2/15/17 Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements The Life Safety Code survey/report will follow. A harm level deficiency was cited at F-323 with past noncompliance Three complaints were investigated during the survey

The census in this 120 certified bed facility was 108 at the time of the survey The survey sample consisted of 19 current Resident reviews (Residents #1 through #19) and 7 closed record reviews (Residents #20 through #26).

F 157 SS=D 483 10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

(g)(14) Notification of Changes

(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-

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention,

(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),

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of

F 000

Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.

This plan of correction is the facility's credible allegation of compliance.

1. Resident # 4's Attending Physician was notified of the blood glucose readings outside of the parameters. The Physician reviewed this resident's medications and parameters on 2-16-17 and made adjustments. Resident #24 was discharged home, prior to this licensure survey. Upon discharge the results of the Blood Glucose levels and all other records were sent to the Resident's Attending Physician for review. 3/31/17
2. An audit will be conducted of current residents that are on blood glucose monitoring.
3. The Unit Managers/ Designee will perform daily blood Glucose Monitoring Audits to verify parameters and notification Compliance, daily times two weeks, then monthly thereafter.
   Nursing will be inserviced related to blood glucose parameters, documentation and proper M.D. notification, as per the order.
4. The Unit Managers or Designee will complete and turn in the audits to the Director of Nursing Services / Designee to ensure compliance. The Director of Nursing / Designee will report the results of the Audits to the QAPI committee monthly to ensure compliance.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Martha C Jamison	Executive Director	3-9-17

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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treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(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

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s)
This REQUIREMENT is not met as evidenced by:
Based on staff interview, resident interview, facility documentation review, clinical record review, hospital documentation, and in the course of a complaint investigation, the facility staff failed to inform the physician of a change in condition for two Residents (Resident #4 and Resident #24) in a survey sample of 26 Residents

1. For Resident #4, the physician was not informed of finger stick blood sugars greater than

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250 on 1/12 at 6:30 a.m. (296); 1/15 at 6:30 a.m. (367), 1/15 at 11:30 a.m. (511), and 1/16 at 11:30 (256), per physician's order

2. For Resident #24, the physician was not informed of a finger stick blood sugar reading greater than 400 on 1/3/17 (457) ,on 1/8/17 (439) and on 1/9/17 (460), per physician's order.

The findings included:

1. Resident #4, a male, was admitted to the facility on 12/1/16. His diagnoses included, but were not limited to, hypertension, diabetes, and end stage renal disease (receiving dialysis).

Resident #4's most recent MDS (minimum data set) with an ARD (assessment reference date) of 2/2/17 was coded as a 14 day Medicare assessment. Resident #4 was coded as having no memory deficits and was able to make his own daily life decisions. Resident #4 was coded as needing minimal to stand by assistance of one staff member with his activities of daily living with the exception of bathing. For bathing, he was coded as requiring extensive assistance of one staff member.

A review of Resident #4's clinical record and hospital documentation was initiated on 2/14/17 at 9:00 a.m.

Resident #4's comprehensive care plan included a plan for Alteration in Blood Glucose due to Insulin Dependent Diabetes Mellitus. Under Interventions read, "12/2/16 - Report abnormal results per Physician parameters."

A review of Resident #4's physician orders

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revealed an order dated 12/3/2016 for Blood Glucose Test three times a day related to Type 2 Diabetes. Call MD (medical doctor), If less than 60 and or greater than 250 "

A review of the January 2017 MAR (Medication Administration Record) revealed the following dates the Blood Glucose measurements were greater than 250 - 1/12 at 6:30 a.m. (296); 1/15 at 6:30 a.m. (367); 1/15 at 11 30 a.m (511), 1/16 at 11.30 (256)

A review of the clinical record revealed the physician was not notified of the Blood Glucose reading of 296 on 1/12, 256 on 1/15 or readings of 367 and 511 on 1/15

A lab obtained on 1/6/17 measured Resident #4's Hgb A1C at 6.6 (reference range 0 0-5 9). (A hemoglobin A1C reading is a measurement of the average blood glucose level over a period of 2-3 months.)

A hospital discharge summary dated 1/16/17 under Admission Information read, "Patent was sent from [facility's name] with Potassium 7.2 (normal range 3.5-5.3)

On 2/14/17 at 11:05 a m., an interview was conducted with the unit manager, LPN (licensed practical nurse) A regarding Resident #4's blood sugar and potassium measurements. LPN A stated, "He is very non-compliant. He is on a Renal Diet, but he eats whatever he likes "

On 2/14/17 at 4:00 p.m , an interview was conducted with the DON (Director of Nursing) at which time she was given a list of the Blood Glucose measurements that were greater than

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250 and without physician notification, per physician ordered parameters. The DON provided a copy of a 3 Step Employee Memorandum regarding LPN E. The DON said LPN E was written up for not reporting the blood sugar reading of 511 on 1/15/17. Attached to the Memorandum was a statement by LPN E, "I miss read a order that said less than 60 and greater the 250 notified MD." Regarding the other blood sugars that were greater than 250 without physician notification, the DON said, "They (the nurses) were misreading the order. We are working on it."

On 2/15/17 at 10:45 a.m., an interview was conducted with Resident #4 who was just returning from a doctor's appointment. Resident #4 said, "Oh, I am non-compliant and I keep trying to get better." Resident #4 said his most recent hospitalization was for high potassium and he had been drinking a lot of Lipton Ice Tea that was very high in potassium. During the interview, Resident #4 emptied his pockets to show he had a hand full of Jolly Rogers candy. Resident #4 said he was very happy and satisfied with the care he was receiving at the facility.

The facility's Blood Sugar Monitoring Policy, under Documentation Guidelines read, " If blood glucose level is above or below parameter range, document the time the physician was notified."

Guidance for nursing practice for the administration of medications is included in, "Fundamentals of Nursing 7th Edition, p. 336, The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients."

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On 2/15/17 at 5:00 p m , the administration was notified of the findings. No additional information was provided

COMPLAINT DEFICIENCY

2. For Resident #24, the physician was not informed of a finger stick blood sugar readings greater than 400 on 1/3/17 (457) ,on 1/8/17 (439) and on 1/9/17 (460), per physician's order

Resident #24 was admitted to the facility initially on 1/18/16 and was readmitted after a hospitalization on 1/19/17. Diagnoses included blindness in right eye, bacteremia, diabetes, alcoholic cirrhosis of liver, hypertension and anemia Resident #24 was discharged from the facility on 1/26/17

A review of the electronic and clinical closed record was initiated on 2/15/16 at 10:00 a m

A 14 day Medicare MDS (minimum data assessment) with an ARD (assessment reference date) of 1/14/17 coded Resident #24 a BIMS (brief interview of mental status) score of "15" out of 15, cognitively intact. Resident #24 was coded as needing staff assistance with toileting and staff supervision only with her other ADLs (activities of daily living)

Resident #24's comprehensive care plan included a plan for Alteration in Blood Glucose due to Insulin Dependent Diabetes Mellitus. Under Interventions read, " Report abnormal results per Physician parameters

The physician orders dated 1/1/17 for Sliding

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Scale Humalog read, "400+=12 Units GIVE 12 U AND CALL MD"

Review of the January MAR (medication administration record) revealed finger stick blood sugar results that were greater than 400 on 1/3/17 (457) ,on 1/8/17 (439) and on 1/9/17 (460)

A thorough review of the clinical record did not reveal any physician notification of the blood sugars in question

On 2/15/17 at 12 55 p m , the DON (director of nursing) was interviewed and asked about the physician notifications on the blood sugars that were greater than 400 After reviewing Resident #24's clinical record, the DON stated, "They were rechecking the blood sugar and if it was OK they didn't call the doctor "

On 2/15/17 at 5:00 p m , the administration was informed of the findings There was no additional information provided

F 157

F 225 SS=D 483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

F 225

(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

1. Resident # 3 was assessed and treated medically, post fall. An investigation was completed to include staff interviews preceding the fracture to determine any factors related to the injury. 3/31/1
2. Current Residents with falls were reviewed within the last 30 days to ensure proper investigations were conducted, causative factors were identified to ascertain if they met the criteria for self-reporting to OLC.

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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

(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,

F 225

3. Licensed Nursing Staff and management will be inserviced on conducting investigations and reporting requirements.
Residents with falls will be reviewed daily during the clinical meeting to ensure appropriate follow has been completed
Management team will be inserviced by The Executive Director regarding conducting investigations and reporting guidelines.
4. Current Residents with new incidents will be reviewed at the Resident at Risk Committee weekly, to ensure a proper investigation was conducted and reported if it meets the criteria. Findings will be reported at the monthly QAPI meeting to ensure compliance.

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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 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 review, clinical record review, hospital medical record review, and in the course of a complaint investigation, the facility staff failed for 1 residents (Resident #3) of 26 residents in the survey sample to report and investigate an injury of unknown origin.

Resident #3 was found with a bruised and swollen right hand on 12/14/16 which was not reported to the State Agency (SA), Office of Licensure and Certification (OLC) as an injury of unknown origin.

The findings included.

Resident #3 was admitted to the facility on 12/21/10 and readmitted to the facility after a hospitalization on 5/23/16 Diagnosis that included, but were not limited to, dementia, anxiety, seizures, pacemaker, hearing loss and cerebral vascular disease

On 2/14/17 at 9:00 a.m., a review of Resident #3's clinical record was initiated

Her most recent MDS (Minimum Date Set) with

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an ARD (Assessment Reference Date) of 1/12/17 was a quarterly assessment. Resident #3 was coded a BIMS (Brief Interview of Mental Status) score of '5" - severe cognitive impairment. She was coded for requiring limited to total assistance of one staff member for her ADLs (Activities of Daily Living). Resident #3 was coded for multiples falls including one with major injury.

On 2/14/17 at 12:00 p.m., Resident #3 was observed in her room sleeping in her bed. Observations on 2/15/17 at 9:00 a.m. also found Resident #3 in her bed with her eyes closed.

Review of the clinical record revealed the following:

1. A comprehensive care plan that included a plan for,
   a. Resident #3's risk for falls "I am at risk for falls related to Hx (history) of multiple falls." Falls listed were - 11/21/16 (sat self on floor); 12/10/16 (Fall minor injury, ER (emergency room) eval, 12/12/16 (Fall with injury, ER eval) 1/10/17 (fall with laceration and Seizure, ER); 2/8/17 (Fall with no injuries, behavior related)
   b. I need pain management and monitoring related to, 12/14/16 - " Fracture of 1st metacarpal."

2. An incident report dated 12/14/16, "Injury BRUISE/CONTUSION. HAND (RIGHT) Physician notified, family notified, resident representative notified, care plan reviewed and revised."

3. An SBAR (Situation, Background,Assessment,Request) documentation:
   a. 12/10/16 - "Fall. Resident observed lying

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on floor, face down with a quarter inch laceration above her left eyebrow. ROM (range of motion) performed without difficulty. MD, RP notified.

b. 12/12/16 - "Resident found on the floor in her room beside her bed. Resident alert, and oriented to self, tolerated medicines well, no c/o pain or discomfort, able to abduct and adduct legs and arms without any difficulty, skin warm to touch, no injuries. MD notified N.N.O. (no new orders) RP notified."

c. 12/14/16 - "Bruise and swelling to right hand. Upon assessing resident noted to right hand and thumb greenish purple in color. Thumb noted to have slight deformity and painful to touch. Resident able to move fingers at this time. Resident has a previous fall on 12/12/16." Tylenol was given and MD and R/P notified. X-ray was obtained.

4. A Radiology Report dated 12/14/16 read, "Modest osteoarthritis of the right hand. Mostly displaced fracture involving the base of the firs metacarpal."

A thorough review of the clinical record did not reveal any investigation into the bruise and swollen hand/thumb that was identified on 12/12/16. Nursing not stated resident #3 had a fall two days prior, however, the bruising, swelling and pain was not definitively documented as having been attributed to the fall. Resident #3 was being assessed by staff via vital signs and Neuro checks for two days without any signs of pain or discomfort expressed by the resident

Resident #3's bruise was identified by staff on 12/14/16 and the cause was not immediately known. The resident was unable to say how it happened. The facility staff attributed it to a fall

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that had occurred two days prior. There was no investigation or interviewing of staff as to what happened during the 24 hours prior to the identification of her injured hand

Review of the facility's policy entitled "Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation" included

"Reporting:

If the reportable event does not result in serious bodily injury, the staff member shall report the suspicion not later than 24 hours after forming the suspicion

Failure to report in the required time frames may result in disciplinary action, including up to termination.

Staff must report the suspicion of an incident to the Executive Director, Director of Nursing, or supervisor

The ED (executive director) notifies the appropriate state agency in accordance with state law and also notifies the regional vice president."

On 2/14/16 at 5:00 p.m., the administrator and the DON (Director of Nursing) were asked if an investigation into the cause of the bruise was conducted and the response was that they related the bruising and swelling to the fall that occurred two days prior.

On 2/15/17 at 5:00 p.m., the administration was informed of the above findings. No additional information was provided

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	COMPLAINT DEFICIENCY			
F 252 SS=D	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	F 252		3/31/17

(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents

(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible

(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk

(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, and facility documentation review the facility staff failed to provide a clean homelike environment for Resident #17.

The facility staff failed to clean Resident #17's bathroom, allowing feces and urine to remain in the toilet for three hours, and a soiled incontinence brief and a urine puddle to remain on the bathroom floor.

Resident #17, a 48 year old male, was admitted to the facility on 1/14/2016. His diagnoses

F252

1. Resident # 17's bathroom and toilet was cleaned on 2-13-17 and urine on the floor in the bathroom and room was cleaned on 2-15-17.
2. An audit will be conducted by the IDT team who will determine if there are any other Residents who may require more frequent rounding in their rooms and bathrooms.
3. Resident rooms which are identified as requiring additional monitoring and cleaning will be placed on a "Hot List." Housekeeping will round frequently on the "Hot Listed" rooms. Any cleaning deemed necessary to maintain a safe and sanitary environment will be completed. Nursing and Housekeeping staff will be inserviced as to the "Hot List", the need to frequently check these rooms and initiate corrective actions.

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included Huntington's Disease, ataxia, and chronic obstructive pulmonary disease.

Resident #17's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/25/2017 was coded as an annual assessment. Resident #17 had a BIMS (Brief Interview of Mental Status) score of 3/15, indicating severe cognitive impairment. He required only supervision for his activities of daily living, and was coded as being frequently incontinent of bladder and always incontinent of bowel.

Resident #17 was observed on the initial tour of the facility on 2/13/2017 at 2:10 PM. He was fully clothed and lying in bed. His bathroom door was open and the bathroom light was on. Feces and urine were observed in the toilet and a urine puddle was seen on the floor in front of the toilet. Resident #17's bathroom was again observed at 5:00 PM, almost 3 hours later, and the situation was unchanged with the toilet unflushed and the urine on the floor

LPN A, Unit Manager was brought to the room to see the bathroom at 5:05 PM. She stated that she would have the bathroom cleaned immediately and that this was unacceptable.

Resident #17 was again observed in his room on 2/15/2017 at 9:30 AM. He was again lying on his bed fully clothed. The bathroom door was open and the light was on. Urine was observed in the toilet, and a soiled incontinence brief and dried urine was seen on the floor. LPN A, Unit Manager was again brought to the room and she stated that she would have it cleaned immediately.

4. The Environmental Services Director will maintain the "Hot List" audits of rounds. The "Hot List" will be reviewed at the weekly Resident at Risk Meeting and changes made as appropriate. Findings will be reported to the QAPI committee monthly to ensure Compliance.

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Resident #17's Care Plan was reviewed and the following items were noted:
" "I sometimes have behaviors which include rejection of care and wandering"
" "I have a physical functioning deficit related to self-care impairment"
" "I have an alteration in the elimination of bowel and bladder "

LPN A stated that she was aware of Resident #17's behaviors and needs.

On 2/15/2017 at 2:00 PM an interview was conducted with Administration E, Corporate Nurse Consultant, who stated that there is a corporate program called "Hot Room" which identified rooms requiring additional monitoring and cleaning. She stated that Resident #17's room should have been included in this program.

The administration was informed of findings on 2/15/2017 at 4:45 PM.

F 274 SS=D 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE

(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the

F 252

F274

3/31/17

1. Resident # 23 no longer resides at the facility.
2. Residents with a documented change in condition for the past 30 days will be reviewed by the interdisciplinary team to determine if the Resident meets the criteria per the RAI manual for a significant change MDS. RNAC will Audit the assessment reference Day (ARD) reference calendar, weekly to ensure assessments have been properly scheduled.

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care plan, or both.)
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed to for one Resident, Resident #23, in a survey sample of 26 residents, to complete a significant change in status assessment.

Resident #23 did not have a significant change in status assessment completed after a hospitalization, a comprehensive assessment was past due

The findings included:

Resident #23, was initially admitted to the facility 8/28/14. Resident #23 was admitted to the hospital on 6/30/16. She was readmitted on 7/28/16. Diagnoses included diabetes, stroke and peripheral vascular disease

Resident #23's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4/18/16 was coded as a quarterly assessment Resident #23 was coded as having short and long term memory deficits and required total assistance in making daily life decisions Resident #23 was coded as needing extensive to total assistance of one to two staff members to perform activities of daily living

A closed record review was conducted Resident #23's last OBRA assessment (Omnibus Budget Reconciliation Act) was a quarterly assessment on 4/18/16. The next assessment date was due within 92 days of the last assessment date. There was no quarterly or comprehensive

F 274

3. A schedule for Significant Change, MDS Assessments will be maintained. Residents returning from the acute Care setting will be assessed by the MDS Coordinator/Designee for a Significant Change assessment. Scheduled Quarterly Assessments will be placed on a calendar before all Care Management team meetings, before completion.
RNAC will review the assessment reference Day (ARD) reference calendar, weekly to ensure assessments have been properly scheduled.
4. RNAC/Designee will review ARD calendar weekly for completed Assessments. Residents care plans will be reviewed at weekly care plan meetings within 14 days of completion of assessment. Findings will be reported at the monthly QAPI meeting to ensure compliance.

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F 274	Continued From page 16 assessment after the date of 4/18/16. Resident #23 was discharged to the hospital on 6/30/16. Resident #23 was readmitted back to the facility on 7/28/16 and was due for an assessment. On 2/15/17 at 2:00 PM, an interview was conducted with the MDS coordinator (Administration C). She stated that the quarterly assessment after the 4/18/16 was not completed as the resident was out of the facility. She did state that a significant change in status assessment should have been completed after her return from the hospital on 7/28/16 On 2/15/17 at approximately 2:00 PM, the DNS (director of nursing services) and the Administrator were notified of above findings	F 274		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification	F278	1. Resident #23, RNAC will complete a modification assessment to include the stage 4 wound. 2. An Audit will be completed on current Residents with wounds for comparison to current MDS's. 3. Weekly meetings will be conducted with the RNAC and wound treatment nurse to review current wounds. 4. Residents with wounds during the ARD period will be compared to the wound report to ensure accuracy. Findings will be reviewed at the monthly QAPI meetings to ensure compliance.	3/31/17

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(1) Under Medicare and Medicaid, an individual who willfully and knowingly-

(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed to for one Resident, Resident #23, in a survey sample of 26 residents, to ensure an accurate MDS assessment.

Resident #23's stage 4 sacral wound was not coded on the quarterly assessment.

The findings included:

Resident #23, was initially admitted to the facility 8/28/14. Resident #23 was admitted to the hospital on 6/30/16. She was readmitted on 7/28/16. Diagnoses included diabetes, stroke and peripheral vascular disease

Resident #23's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4/18/16 was coded as a quarterly assessment Resident #23 was coded as having short and long term memory deficits and required total

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assistance in making daily life decisions. Resident #23 was coded as needing extensive to total assistance of one to two staff members to perform activities of daily living. There were no pressure ulcers included in the MDS.

A closed record review was conducted. Under section M0300, "Does this resident have one or more unhealed pressure ulcer (s) at stage 1 or higher, the MDS was coded as "0" or no.

Review of the wound tracking for the week of 4-6-16, Resident #23 had a stage 4 sacral pressure wound measuring 5.2 cm (centimeters) by 3.0 by 3.5 cm. The wound contained 15 % necrosis (dead, devitalized tissue. There were no measurements for the week between 4-6-16 and 4-25-16. The measurements for the week of 4-25-16 were 4.3 cm by 3 3 by 3.5 cm.

On 2/15/17 at 2:00 PM, an interview was conducted with the MDS coordinator (Administration C). She stated, "The pressure ulcer was not picked up on the 4-18-16 assessment; it dropped off the 4-4-16 assessment."

On 2/15/17 at approximately 2:00 PM, the DNS (director of nursing services) and the Administrator were notified of above findings

F 281 SS=D 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

(b)(3) Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

F281

1. The Nurse identified for resident #7 received disciplinary action as well as additional inservice education. She is no longer employed by the facility.
Resident #9 is receiving Med's and Treatments perM.D. orders. 3/31/17

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(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation review, clinical record review and in the course of a complaint investigation, the facility staff failed for 2 residents (Resident #7 & #9) in a survey sample of 26 residents, to follow professional standards of nursing for medication and treatment administration.

1. For Resident #7, the facility staff (Licensed Practical Nurse-E (LPN-E) put medication in milk in the dietary department and expected the dietary staff to deliver it to the resident

2. The facility staff failed to document multiple treatments as having been administered for Resident #9.

The findings included:

1. Resident #7 was admitted to the facility on 9/7/16 and readmitted after hospitalization on 10/19/16 with the diagnoses of, but not limited to, dementia, affective mood disorder, end stage renal disease, anxiety and depression.

The most recent Minimum Data Set (MDS) was a significant change assessment with an Assessment Reference Date (ARD) of 12/28/16 The MDS coded Resident #7 with severe cognitive impairment; behaviors not directed towards others, wandering; required extensive assistance from staff for all activities of daily living except bathing in which he was dependent on staff. Resident #2 had moderate impairment of vision with blindness in one eye.

F 281

2. An audit of current MAR's and TAR's for the Past 14 days will be conducted.
3. Random Med Pass observations of Licensed Nurses
will be completed weekly. MAR's and TAR's will be reviewed daily for completion. Licensed Nurses will be inserviced on Med Pass Policies and Procedures
and appropriate documentation requirements.
4. Findings of the Med Pass Observations and MAR and TAR audits will be reviewed at the monthly QAPI meetings to ensure compliance.

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On 2/13/17 at 4:35 p.m , Resident #7 was observed in a high back wheelchair near the nursing desk. He was alert, conversational, joking with staff and surveyor. Resident #2 stated he was at the facility "for about a year" and participated in rehab doing "jumping jacks and moves all over the place." Resident #7 kept kept his right eye closed during the interaction

During the course of the complaint investigation that Resident #7 was included in, it was revealed in LPN-E's employee record that on 10/30/16 LPN-E reportedly took medication to the kitchen and placed them in a residents (Resident #7) food. LPN-E then left items in the kitchen to be delivered with trays. The information was documented on a "3 Step Employee Memorandum" form.

A statement written by the dietary aide (Other-C) read:
"A nurse asked for a milk. I gave one to her She put medicine in it, gave it back to me, and asked us to put the milk on a patients tray-I think (Resident #'7's name). We forgot to put it on tray. I sent it down with someone else and realized it was the wrong patient I went back and the nurse said she had discovered the mistake "

LPN-E's signed written statement included:
"I crush medication and took medication to kitchen to place in mild for (Resident #7 name) I left The milk in kitchen (with symbol) medication in it to be place in tray. Kitchen lady brought the milk to floor and I told (female name) to give it I be more responsible and watch how I five medications I will keep 5 medication rights in my mind at all times. I will not tell people to give what

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I have pop out or torn packet to my resident I will not put medication in resident food ever again I will only crush pill (with symbol) apple sauce only I will not put my resident in harm way ever again."

When asked what professional standard was used for the facility's policies, the Corporate Nurse (Admin-E) explained that multiple sources were used and the source is used depending on the policy topic. The facility's medication administration policy was requested.

Facility policy titled "Specific Medication Administration Procedures Administration Procedures For All Medication" dated 06/15 with the source listed at the bottom of the policy as "Pharmacy Services for Nursing Facilities 2006 American Society of Consultant Pharmacists and MED-PASS, Inc. (Revised August 2014) included the following.
"C. Review 5 Rights (3) times:...
1) e. Prepare resident for medication administration...
E. Identify resident using (two) identification methods before administering medication (e g., photo plus verbal confirmation of last name, photo and confirmation by family member, etc)
K. Monitor for side effects or adverse drug reactions immediately after administration and throughout each shift
L. If resident refuses medication, document refusal on MAR or TAR (medication administration record or treatment administration record). Research refusals for possibility of dry mouth, resident reluctance, development of swallowing difficulty..."

On 2/14/17 at 3:10 p m., Resident #7's clinical record was reviewed. The review revealed

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LPN-E administered medications to Resident #7 on the 3 p.m.-11 p.m. shift on the following dates in October 2016 10/7, 21, 29 & 30. There was no documentation on those dates that Resident #7 refused his medications or the medications were held The medications documented as administered by LPN-E included Alprazolam-for anxiety disorder, Amlodipine-for hypertension, melatonin-for insomnia, Quetiapine-for affective mood disorder, Remeron-for depression, trazodone-for insomnia, Colchicine-for gout, Ferrous Sulfate-for end stage renal disease, Furosemide-for hypertension, megestrol acetate-for appetite stimulant, Keppra-for seizure, and protonix-for reflux The medications administered on the date of the incident (10/30/16) are in bold

On 2/15/17 at 2:00 p.m an interview was conducted with the Director of Nursing (Admin-A). The medication event was discussed. Admin-A explained that Resident #7 would refuse to take meds. She stated the LPN "Was counseled and re-educated." When asked what happened to the milk with the medication in it, Admin-A stated "The med in the milk got to the nursing station but was not administered to the resident or wrong resident." When asked how she found out about the incident, Admin-A stated "Dietary staff brought it to the dietary manager who brought incident to me." When asked if LPN-E was still employed at the facility,
Admin-A stated she was. LPN-E's employee record included the counseling (3 Step Employee Memorandum) which was checked as LPN-E's 1st Disciplinary Action, education on facility policy on medication administration, rights of medication administration and proper "chain" and responsibilities of giving meds

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On 2/15/17 at 3:35 p.m., the Administrator and Corporate Nurse, with Admin-A present were informed of the findings.

Complaint Deficiency.
2. The facility staff failed to document multiple treatments as having been administered for Resident #9.

Resident #9, a 93 year old female, was admitted to the facility on 9/10/2008 and readmitted on 8/11/2010. Her diagnoses included dementia with disturbances, peripheral vascular disease, depression, psychosis, hypothyroidism, osteoarthritis, coronary artery disease, hypertension, muscle weakness, reflux, anxiety, anemia, uterine cancer, and breast cancer.

Resident #9's most recent MDS (Multiple Data Set) with an ARD (Assessment Reference Date) of 11/18/2016 was coded as a quarterly assessment. Resident #9 had a BIMS (Brief Interview of Mental Status) score of 3/15, indicating severe cognitive impairment. She required extensive assistance of one person for her activities of daily living and was always incontinent of bowel and bladder.

A review of Resident #9's clinical record was conducted on 2/14/2017 at 9:45 AM. It revealed TAR's (Treatment Administration Records) for November and December 2016 and January 2017 showing treatments not documented as having been given for the following treatments per physician's orders on the dates and times indicated:

"Chair alarm every day and evening

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shift"-11/11/2016, evening shift 12/10 day shift, 1/22 evening shift.
"Assist side rails on bed to assist with positioning and mobility every shift"-11/11 evening shift, 12/10 day shift, 12/16 day shift, 1/22 evening shift
"Bed alarm (check)"-11/11 evening shift, 12/10 day shift, 12/16 night shift, 12/22 evening shift.
"Geri Sleeves every shift to bilateral arms"-11/11 evening shift, 12/10 day shift, 12/16 night shift, 1/22 evening shift.
"Pads to arms of wheelchair at all times"-11/11 evening shift, 12/10 day shift, 12/16 night shift, 1/22 evening shift
"Remove lap buddy from wheelchair for 10 min every hour and at meal times"-11/11 evening shift, 12/10 day shift, 12/16 night shift, 1/22 evening shift
"Wanderguard continuous every shift"-11/11 evening shift, 12/16 night shift, 12/22 evening shift, 1/22 evening shift.

Administration A, Director of Nursing was informed of these omissions at the end of day meeting on 2/14/2017 at 4:50 PM She could offer no explanation for this.

During an interview with Administration E, Corporate Nurse Consultant, on 2/15/2017 at 2:00 PM, she stated that multiple sources are used for compiling nursing standards

Guidance for nursing practice for following physicians' orders was included in Potter and Perry-"Fundamentals of Nursing 7th Edition p336 which states "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients "

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F 281	Continued From page 25 Administration was informed of findings at 4:15 PM at 4:45 PM.	F 281		
F 323 SS=G	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. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record review, the facility failed for one Resident (Resident #20) in a survey sample of 26 residents, to ensure a safe living environment, resulting in harm (facial fractures and lacerations requiring sutures). This was a	F 323	Past noncompliance no plan of correction required.	

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past noncompliance.

Resident #20 did not have his elevating leg rests as indicated for trunk instability. Resident #20 fell, causing facial fractures and two lacerations requiring sutures

The findings included:

Resident #20, was initially admitted to the facility 2/26/15. Diagnoses included Parkinson's Disease, anemia and seizure disorder

Resident #20's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6/4/16 was coded as a quarterly assessment. Resident #20 was coded as having short and long term memory deficits and required moderate assistance in making daily life decisions. Resident #20 was coded as needing extensive assistance of one to staff members to perform activities of daily living.

Resident #20 no longer resided in the facility, so a closed record review was conducted An FRI (facility reported incident) was sent to the OLC (office of licensure and certification) regarding a fall which occurred on 4/18/16. The resident was found on the floor, having sustained a fracture of the right orbit of the eye, maxillary bone and zygomatic arch of the face In addition, the resident sustained two lacerations above the right eye, requiring sutures. The resident required pain medication after the fall. The leg rests were to maintain trunk stability as the resident leaned forward in his wheelchair. The resident's care plan dated (3-18-16) included the potential for falls, and included the intervention dated 4/19/16 for high back w/c with elevated leg rests to be on

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when resident up in chair. Prior to this intervention (3-18-16) was the intervention "Assess that wheelchair is of appropriate size, assess need to have w/c locked/unlocked for safety, antitippers." In addition to his ADL's, the resident did not stand or ambulate and was total care for transfer, ambulation on unit and toileting Information concerning the leg rests were to be on the wheelchair, and the legs elevated was not communicated to the nursing department from rehab. The rehab assessed and determined that the leg rests were neccessary to prevent falls According to the facility investigation, this was the causative factor in the subsequent fall with fracture.

A four point action plan was implemented to ensure that all communication between the departments is received and implemented in a timely manner.

Review of the 4 point POC (plan of correction) dated 4/21/16 included the following:

1. The resident's care plan and care card were updated to indicate the need for footrests his wheelchair when up. The incident was reported to the state on 4/20/16 and an investigation was initiated.

2. All residents with therapy recommendations have the potential to be affected

3. Therapy staff will be inserviced on the process of communicating any equipment or device needed for residents to the nursing department through the Clinical start up and stand down (daily meeting) process. The DOR (director of rehab) will ensure that she or a designee attends

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F 323	Continued From page 28 the clinical start up and stand down to provide that communication to the nursing department. 4. The DOR or designee will review therapy recommendations daily to ensure that all recommendations have been communicated to nursing. The DNS (director of nursing services) will review all orders during Clinical Start Up and Stand Down to ensure that all recommendations from therapy have been communicated and incorporated on to the care plans and care cards. 5. The AOC (allegation of compliance) date was May 18, 2016 The above POC was reviewed and had been implemented. On 2/15/17 at approximately 11:00 AM, the Administrator was asked if there any issues with therapy communication with nursing after the above incident. He stated, "no." On 2/15/17 at 1:20 PM, the DOR (other D- a COTA- certified occupational therapy assistant) was interviewed. She stated, "For any changes I do a nursing communication and take to unit manager." She also stated that these are reviewed in the daily Stand Up meeting. On 2/15/17 at approximately 2:00 PM, the DNS and Administrator were notified of above findings	F 323		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when	F329	1. Resident # 2, lab results indicated that Glucose levels were stable. The physician reviewed and discontinued the parameters regarding the Glipizide.	3/31/17

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F 329	Continued From page 29 used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure one (Resident #2) of 26 residents in the survey sample, was free from unnecessary medication. Resident #2 was administered the diabetic medication, glipizide, when it should have been held due to physician ordered blood glucose parameters. The findings included. Resident #2 was admitted to the facility on 6/15/16 with the diagnoses of, but not limited to, diabetes mellitus type 2, hypertension and cardiac arrhythmia. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment	F 329	2. Current Residents who require Glucose monitoring, record's will be audited. 3. Nursing Staff will be inserviced related to medications with parameters and proper administration, documentation and physician, R.P. notification. 4. Unit Managers/Designee will complete bi-weekly Audits of Residents with Glucose parameters for 4 weeks, then random audits monthly times 2 months. Findings will be reviewed by the QAPI committee monthly to ensure compliance.	

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Reference Date (ARD) of 12/15/16. The MDS coded Resident #2 with intact cognition; required extensive assistance from staff for bed mobility, dressing, eating and hygiene; was dependent on staff for transfers, toileting and bathing.

On 2/14/17 at 1:30 p.m. Resident #2's clinical record was reviewed. The review revealed signed physician's orders which included. "Glipizide Tablet Give 2.5 mg (milligrams) by mouth one time a day related to TYPE 2 DIABETES MELLITUS...hold if BS <110 (blood sugar level below 110 mg/dL (milligrams per deciliter)

Review of the Medication Administration Record (MAR) for January and February 2017 revealed the Glipizide was administered, even though the blood sugar results were below the physician ordered parameter, on the following dates at 8 a.m.:
1/8/17=99, 1/9/17=99, 1/10/17=99, 1/12/17=102. 1/15/17=98 and
2/1//17=97 and 2/13/17=109.

On 2/14/17 at 2:35 p.m. an interview was conducted with the Unit Manager, Registered Nurse-A (RN-A). RN-A was informed of the Glipizide documented as administered with the blood sugar results below the physician ordered parameter. RN-A stated she'd look into it. At 3:00 p.m., RN-A stated she "Couldn't find any other documentation of blood sugars." When asked what her expectations were, RN-A stated "I expect them (nurses) to follow the parameters as ordered."

On 2/14/17 at 4:50 p.m., the Administrator and Director of Nursing were informed of the findings.

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F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333	F 333	

(f)(2) Residents are free of any significant medication errors.
This REQUIREMENT is not met as evidenced by:
Based on staff interview facility documentation and clinical record review, the facility staff failed to ensure 1 resident (Resident #22) of 26 residents in the survey sample was free from a significant medication error

Resident #22 did not receive his physician ordered Klonopin for six doses resulting in an increase in behaviors and psychotropic medications

The findings included:

Resident #22 was admitted to the facility on 12/24/15 and was readmitted on 3/18/16. Diagnoses included Intellectual Disability, congestive heart failure, anxiety and psychosis. The most recent MDS (minimum data set) dated 6/24/16 coded the resident's BIMS (brief interview of mental status) score of "0" out of a possible 15, or severe cognitive impairment. The MDS coded the resident as requiring supervision assistance of one staff member for ADL's (activities of daily living) such as locomotion on and off the unit.. The resident was coded as having been treated with an antipsychotic and antianxiety daily for the past seven days of the ARD period.

Resident #22 was no longer in the facility. A FRI (facility reported incident) dated 5/30/16 was submitted to the OLC (office of licensure and certification) regarding an episode of aggression

F 333

1. Resident # 22 – this Resident no longer resides at this facility. The Employees who failed to administer medications as per the physician's orders, employment was terminated. 3/31/17
2. A 100% audit was conducted by the Director of Nursing regarding narcotic count reconciliation. Random audits will be completed by the Director of Nursing/Designee for three months.
3. Licensed Nurses will be inserviced on controlled Substance Policy.
4. Findings of the Audits will be reported at the monthly QAPI Committee meetings to ensure compliance.

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in which he entered the therapy gym and began yelling and throwing objects at staff, hitting one staff member in the chest; he also threw an empty soda can, and was reaching and striking out at other residents in his path. No one was injured

Further review of the FRI revealed the resident had a physician's order for Klonopin 0.5 mg (milligrams) three times daily. The FRI revealed the following. "Upon reviewing medication regimen and lost dose received, it was noted that although signed off on the MAR (medication administration record) , the medication in question had not been signed out on the narcotic sheet as required A count of medication was conducted and was found to correspond with the recorded count at that time. It was found that (name of resident) had only received one of the scheduled six doses of medication scheduled for the 28th and 29th of May The MD was notified and medication was given. (Name of resident) is currently receiving his medications as scheduled "

Review of the clinical record revealed on 5/29/16, the resident refused his medication, swinging his arms and saying no. On 5/30/16, the resident had the incident in the therapy room. The physician was notified and the Seroquel (antipsychotic) medication was increased to Seroquel 50 mg every 8 hours prn (as needed). The resident received this on 6/1/16, 6/2/16 (twice), 6/4/16 and 6/7/16. The resident also received Ativan one mg IM (intramuscularly) on 6/2/16.

On 5/31/16 at 5:30 PM, the resident began yelling, tried to spit on staff. On 6/2/16, the resident was taking his clothes off and was

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F 333	Continued From page 33 aggressive toward staff. On 4/18/16, the psychiatry notes included the following: On 3/23/16, "Klonopin was increased to three times a day" due to increased behaviors. On 4/18/16, Oxcarbazepine to 300 mg for agitation by the psychiatrist. Review of the policy and procedure for Administration Procedures for all medications, step J included the following: "After administration, return to cart, replace medication container... and document administration on the MAR and controlled substance sign out record." On 2/15/17 at approximately 2:00 PM, the Facility Administrator and DNS (director of nursing services) were notified of above findings.	F 333		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483 70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures	F 441	1 Resident # 17's bathroom and toilet was cleaned on 2-13-17 and urine on the floor in the bathroom and room was cleaned on 2-15-17. 2. An audit will be conducted by the IDT team who will determine if there are any other Residents who may require more frequent rounding in their rooms and bathrooms.	3/31/17

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F 441	Continued From page 34 for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (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.	F 441	3. Resident rooms which are identified as requiring additional monitoring and cleaning will be placed on a "Hot List." Housekeeping will round frequently on the "Hot Listed rooms. Any cleaning deemed necessary to maintain a safe and sanitary environment will be completed. Nursing and Housekeeping staff will be inserviced as to the "Hot List", the need to frequently check these rooms and initiate corrective actions, as well as the infection control policy. 4. The Environmental Services Director will maintain the "Hot List" audits of rounds. The "Hot List" will be reviewed at the weekly Resident at Risk Meeting and changes made as appropriate. Findings will be reported to the QAPI committee monthly to ensure Compliance.	

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FORM APPROVED
OMB NO. 0938-0391

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
	495252	A. BUILDING _____ B. WING _____	C 02/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-BATTLEFIELD PARK	250 FLANK ROAD PETERSBURG, VA 23805

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F 441	Continued From page 35	F 441		

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility documentation review the facility staff failed to implement an effective infection control program for Resident #17

The facility staff failed to clean Resident #17's bathroom, allowing feces and urine to remain in the toilet for three hours, and a soiled incontinence brief and a urine puddle to remain on the bathroom floor.

Resident #17, a 48 year old male, was admitted to the facility on 1/14/2016. His diagnoses included Huntington's Disease, ataxia, and chronic obstructive pulmonary disease

Resident #17's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/25/2017 was coded as an annual assessment. Resident #17 had a BIMS (Brief Interview of Mental Status) score of 3/15, indicating severe cognitive impairment. He required only supervision for his activities of daily living and was coded as being frequently incontinent of bladder and always incontinent of bowel.

Resident #17 was observed on the initial tour of the facility on 2/13/2017 at 2:10 PM. He was fully clothed and lying in bed. His bathroom door was

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	495252	A. BUILDING _____ B. WING _____	C 02/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-BATTLEFIELD PARK	250 FLANK ROAD PETERSBURG, VA 23805

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F 441	Continued From page 36	F 441		

open and the bathroom light was on. Feces and urine were observed in the toilet and a urine puddle was seen on the floor in front of the toilet. Resident #17's bathroom was again observed at 5:00 PM, almost 3 hours later, and the situation was unchanged with the toilet unflushed and the urine on the floor.

LPN A, Unit Manager was brought to the room to see the bathroom at 5:05 PM. She stated that she will have the bathroom cleaned immediately and that this was unacceptable

Resident #17 was again observed in his room on 2/15/2017 at 9:30 AM. He was again lying on his bed fully clothed. The bathroom door was open and the light was on. Urine was observed in the toilet, and a soiled incontinence brief and dried urine was seen on the floor. LPN A, Unit Manager was again brought to the room and she stated that she will have it cleaned immediately.

Resident #17's Care Plan was reviewed and the following items were noted:
o "I sometimes have behaviors which include rejection of care and wandering"
o "I have a physical functioning deficit related to self-care impairment"
o "I have an alteration in the elimination of bowel and bladder "

LPN A stated that she was aware of Resident #17's behaviors and needs.

On 2/15/2017 at 2:00 PM an interview was conducted with Administration E, Corporate Nurse Consultant who stated that there is a corporate program called "Hot Room" which identified rooms requiring additional monitoring

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F 441	Continued From page 37 and cleaning. Resident #17's room should have been included in this program Facility "Infection Prevention and Control Policy" stated "Important facets of infection prevention include educating staff and ensuring that they adhere to proper techniques and procedures" The administration was informed of findings on 2/15/2017 at 4:45 PM	F 441		

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20response%20form.pdf. We will appreciate your participation.

If you have any questions concerning this letter, please contact me at 804/367-2100.

Sincerely,

Rodney L. Miller, LTC Supervisor
Division of Long Term Care

Enclosure

cc: Joann Atkins, Dmas (Sent Electronically)

COMMONWEALTH of VIRGINIA

Department of Health

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

Office of Licensure and Certification

TYY 7-1-1 OR
1-800-828-1120
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

March 2, 2017

Mr. Matthew Farmer, Administrator
Golden Livingcenter-Battlefield Park
250 Flank Road
Petersburg, VA 23805-9117

RE: Golden Livingcenter-Battlefield Park
Provider Number 495252

Dear Mr. Farmer:

An unannounced standard survey, ending February 15, 2017, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. Three complaints were investigated during the survey. One complaint was substantiated, with deficiencies. Two complaints were unsubstantiated, with no deficiencies.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was an isolated deficiency that constitutes actual harm that is not immediate jeopardy (S/S of G), as evidenced by the attached CMS-2567L, whereby significant corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Elaine Cacciatore, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. **If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.**

To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at http://www.vdh.state.va.us/OLC/longtermcare/.

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Center within 10 calendar days of your receipt of the enclosed survey findings. **An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.**

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

- Pursuant to §488.408(c)
  - Directed Plan of Correction (PoC) (§488.424).
  - State monitoring (§488.422).
  - Directed In-Service Training (§488.425).
- Pursuant to §488.408(d)
  - Denial of payment for new admissions - (§488.417).
  - Denial of payment for all individuals - (§488.418).
  - Civil Money Penalty, $50 - $3,000 per day (§488.430, §488.438), effective on the survey ending date.
- Civil money penalties of $1,000 - $10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

Please be advised: The facility must maintain compliance with both the Health and Life Safety Code requirements in order to continue provider certification.