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CONSULATE HEALTH CARE OF WOODSTOCK	803 SOUTH MAIN ST WOODSTOCK, VA 22664

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An unannounced Medicare/Medicaid standard survey was conducted 6/19/17 through 6/21/17 Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 88 certified bed facility was 80 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents 1 through 13) and 6 closed record reviews (Residents 14 through 19).

F 155 SS=G	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES	F 155	

483.10
(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).

(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
H. Lauer	Executive Director	7-13-17

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

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F 155	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to preserve a resident's right to execute an advance directive regarding steps to be followed in the event she became without heartbeat and not breathing in	F 155	Past noncompliance: no plan of correction required.	

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the facility.

Resident #14 had signed an advance directive stating she wanted all resuscitative efforts to be undertaken for her. In accordance with this advance directive, the physician had written an order that the resident would be a full code. On 12/4/17, Resident #14 was discovered to be without pulse and without respirations. The facility staff failed to honor the advance directive and follow the physician's order by immediately beginning CPR and calling for emergency medical assistance, and Resident #14 subsequently expired.

The findings include:

Resident #14 was admitted to the facility on 11/24/16 with diagnoses including, but not limited to: ovarian cancer which had spread, diabetes, nausea, and vomiting. On the most recent MDS (minimum data set), an admission assessment with an assessment reference date of 12/1/16, Resident #14 was coded as being severely cognitively impaired for making daily decisions, having scored only three out of 15 on the BIMS (brief interview for mental status).

A review of the admission nursing assessment dated 11/24/16 revealed that Resident #14 was alert and oriented to person only.

A review of Resident #14's clinical record revealed a page with the title "FIRST ALERT." This page contained the following: "CODE ALERT: FULL."

Further review of the clinical record revealed the document "[Name of state] Advance Directive for

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Health Care." This document stated, in part: "I [name Resident #14] willingly and voluntarily make known my wishes in the event that I am incapable of making an informed decision about my health care, as follows:...Section II: My Health Care Instructions...I provide the following instructions in the event my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover...I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable." This document listed the names of one individual to serve as primary agent, and another individual to serve as secondary agent. This document was signed by Resident #14 and dated 11/22/16.

Further review of the clinical record revealed a document with the title "Advance Directives Discussion Document." The document stated, in part: "Please indicate your wishes regarding the following: Cardiopulmonary Resuscitation (CPR): PROVIDE. Please indicate if you possess any of the following documents or have primary decision-maker." The document contained a check mark beside the categories of advance directive and health care agent. The document continued: "I have received a copy of the facility's policies on Advance Directives and have been given a chance to ask questions regarding my rights to make decisions regarding my medical care. I understand that I have the right to refuse or accept medical and/or surgical treatment, and the right to formulate advance directives concerning my health care. Honoring resident choices requires providing appropriate documentation, and I understand that I am

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responsible for providing the facility with the necessary and/or legal documentation appropriate for Advance Directives." The document was signed by Resident #14 and by the primary agent designated in the Advance Directive for Health Care.

A review of the physician's orders for Resident #14 revealed the following order, dated 11/24/16 and signed by the physician on 12/1/16: "Code - full."

A review of Resident #14's comprehensive care plan dated 11/24/16 revealed no information related to her advance directive or code status.

A review of the nurses' notes for Resident #14 revealed, in part, the following:
- 12/3/16 - 12/4/16 "7p - 7a (7:00 p.m. on 12/3/16 through 7:00 a.m. on 12/4/16) - Resident resting quietly. [Arrow pointing up] (increased) temp (body temperature). No c/o (complaint of) pain. No SOB (shortness of breath)/cough noted. Call bell in reach. Will cont (continue) to monitor.
- @ (at) 130 (1:30 a.m.), CNA (certified nursing assistant) went into take resident's temp and found her with no pulse and not breathing. Blue around lips and nail beds. ADCS (assistant director of clinical services [*note at the time of this incident the current director of clinical services, administrative staff member #2, held the position of assistant director of clinical services]) and Dr. (doctor) notified." Both of these notes were signed by LPN (licensed practical nurse) #10.
- "12/4/16 0245 (2:45 a.m.) Pt (patient) without respiration, no apical heart rate present. Pt (patient) expired, pt identified as full code @ this time. 2nd (second) nurse verified. CPR initiated.

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EMS (emergency medical services) called. MD (medical doctor [physician]) made aware and RP (responsible party)." This note was signed by ASM (administrative staff member) #2, the director of clinical services.

Further review of the clinical record revealed the following order, dated 12/4/16 and was signed by ASM #3, the nurse practitioner, on 12/7/16: "Send to ER (emergency room) for eval (evaluation) and treat (treatment)."

A review of the EMS (Emergency Medical Service) record for Resident #14 dated 12/4/16 revealed, in part, the following: "Dispatched to [facility] for a person in cardiac arrest. On scene, in [Resident #14's room number], found a 72 YOF (year old female) lying supine on the bed with staff performing CPR on the pt and was (sic) bagging her with bi-valve mask. Staff was asked if there were a DNR (do not resuscitate) and they advised that she is a full code. Pt was found in cardiac arrest while the nurse was doing rounds. Unknown down time. CPR was started and 911 called. General impression was poor. Pt was unresponsive. Pt was not mobile. Pt was unstable. Pt was logged rolled (sic) onto a backboard and the Lucas device (automatic CPR machine) was place and was initiated to take over CPR. Care was transferred to [name of EMS company]. Medical hx (history) was obtained from staff. Pt allergies are unknown...Pt was picked up and carried out to the cot and placed on it and secured...Pt had no signs of life. Pt was transported to [name of local hospital]...On arrival to [name of local hospital], pt was still unresponsive and not breathing."

A review of the records from the local hospital

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dated 12/4/16 revealed, in part, the following: "Emergency History and Physical Exam: "[Name of Resident #14] is a 72 y.o. (year old) female who presents by EMS. Apparently the patient was found on the floor unresponsive in (sic) cyanotic around at the nursing home...unknown how long she had been down...Differential diagnosis considered includes: Dead on arrival...The patient was pronounced dead at 3:43 a.m. Death certificate completed. Clinical Impression: Dead on arrival."

A review of the report sent to the state agency dated 12/6/16 revealed, in part, the following: "[Name of Resident #14] was a 72 year old female admitted to this facility on 11/24/16...Her advanced directive requested full code status. On 12/4/16 at 0130 (1:30 a.m.), [Resident #14] presented as unresponsive to the on shift CNA. The CNA reported this to LPN Charge Nurse [name of LPN #10], who noted the resident as having no pulse, no breathing and presenting with blue lips and nail beds. [LPN #10] phoned [ASM #2] and requested that she come to the facility and pronounce death. On arrival, [ASM #2] also noted [Resident #14] to be absent of vital signs; but identified [Resident #14] as a full code and initiated the facility CPR policy and transferred [Resident #14] via EMS to the local emergency department...After facility investigation, neglect has been substantiated. [LPN #10's] employment with this facility has been terminated and required reporting will occur to the Department of Health Professions."

A review of the facility's investigation file about this incident revealed the following statement written by LPN #3 and dated 12/5/16: "On December 4, 2016, [LPN #10] asked me to come

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and check patient with her. Listened to heart and lungs nothing heard (sic). [LPN #10] was nonchalant with the situation told (sic) me patient had been declining and had hx (history) of CA (cancer). This lead (sic) me to believe that the patient was comfort and expecting to go any time."

Further review of the facility's investigation file revealed the following statement written by LPN #10 dated 12/4/16: "At 0130 (1:30 a.m.) I sent CNA to take temp of resident. Earlier she had a temp of 100.1. CNA called me to the resident's room. Found resident without resp (respirations) and very pale and turning cold. (Resident had been checked on an hour prior.) At this point I called another nurse to listen for heart rate/breath sounds. At this point I texted the ADCS (assistant director of clinical services) and left a message and she returned the called (sic). At this point, I was unaware the resident was a full code. When the ADCS arrived we began CPR and called the squad (EMS)."

On 6/20/17 at 1:45 p.m., LPN #5 was interviewed. When asked what she would do if a staff member reported to her that a resident under her care had been found without pulse and without respirations, LPN #5 stated: "I would page a code blue." She stated the process is for two nurses to check the resident's chart and clarify the physician's order. If the resident is a full code, "somebody starts CPR and somebody else makes the calls and does the paperwork." She stated the facility provides frequent training and code blue drills for the staff.

On 6/20/17 at 2:40 p.m., LPN #4 was interviewed. When asked what she would do if a staff member

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reported to her that a resident under her care had been found without pulse and without respirations, LPN #4 stated: "I would grab the chart to see whether or not they are a DNR." She stated if the resident was not a DNR, she would assess the resident and start CPR if there were no vital signs. She stated she would get other staff members to call the rescue squad, family, and physician.

On 6/20/17 at 3:40 p.m., ASM #3, the nurse practitioner, was interviewed. When asked if a resident has an order to be a full code, and if that resident ceased heart rate and respirations, what should be done, ASM #3 stated: "The resident should be coded." ASM #3 stated: "The underlying diagnosis doesn't matter. If it's the middle of the night and the resident is a full code, we must start CPR and call 911." She added that she is aware that the facility practices this scenario by way of code blue drills frequently.

On 6/21/17 at 7:05 a.m., CNA #1 was interviewed. She stated that she was assigned to Resident #14 on the night of 12/3/16 through 12/4/16. She stated the resident had a fever earlier in the shift, and that LPN #10 had asked her to re-check the resident's temperature. CNA #1 stated when she entered the resident's room, "it looked like she was dead. She was gray." She stated she stepped out of the room and called for LPN #10 to come to the room. CNA #1 stated: "[LPN #10] never looked at the chart. She immediately yelled for LPN #3 to come and help her. They both went in the room and checked [Resident #14]." She stated she remembered the nurses talking to each other about who was on call for the facility to pronounce death, and that neither of them discussed the

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resident's code status. She stated one of the nurses called ASM #2, the director of clinical services and that it was "a good while" before ASM #2 arrived at the facility. CNA #1 stated ASM #2 "came in and pronounced [Resident #14's death]." She stated ASM #2 went to do paperwork at the desk, and discovered that Resident #14 was a full code. CNA #1 stated ASM #2 started CPR and other staff called emergency services.

On 6/21/17 at 7:10 a.m., LPN #3 was interviewed. LPN #3 stated: "I was working on my side and [LPN #10] yelled for me to go help her. We went in the room. [Resident #14] was gray and cold. [LPN #10] told me the resident had cancer, and had been declining. She told me the resident had basically given up. I thought she was on comfort care. We both assessed her." LPN #3 stated there were no signs of life, and there was no discussion of the resident's code status. LPN #3 stated LPN #10 called ASM #2. ASM #2 arrived at the facility and "they started CPR. I really don't know what happened after that because I went back to work on my side."

On 6/21/17 at 7:20 a.m., ASM #2, (the director of clinical services [who at the time of this incident was in the position of assistant director of clinical services]) was interviewed. ASM #2 stated during the early morning hours of 12/4/16, she received a call from LPN #10. She did not remember the exact time, and stated LPN #10 left a voicemail for her. ASM #2 stated: "At some point I woke up and checked the voicemail. I came in, went in the room. I observed [Resident #14] was not breathing, no pulse, and no blood pressure. I went down to the desk and started to write the note and saw the green spine on the chart." ASM

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#2 stated a green spine indicates that a resident has a physician's order for a full code. She stated when she checked the chart for the physician's order, she discovered that Resident #14 was a full code, and she went and "started CPR on her (Resident #14)." ASM #2 stated the EMS arrived, took over the CPR and transported the resident to the emergency room. She stated she called ASM #4, the attending physician, later in the morning and told him what had happened.

On 6/21/17 at 7:35 a.m., ASM #4 was interviewed. He stated he did not remember being called by LPN #10 to inform him that Resident #14 had been discovered in her room without signs of life. He stated he remembered ASM #2 calling him later to inform him of what had happened. When asked what process was to be followed when a resident who has a full code order is discovered without signs of life, ASM #4 stated: "We should immediately call a code and call 911, and we should immediately begin resuscitative efforts."

The administrator and director of nursing at the time of this incident are no longer employed by the facility.

On 6/21/17 at 8:35 a.m., ASM #1, the executive director, and ASM #2 were informed of these concerns. At this time, the survey team informed these staff members of the concern for harm.

A review of the facility policy "Advance Directives - Nursing" revealed, in part, the following: "The facility nursing staff will abide by resident advance-directives, if known, and if those directives are not in conflict with Federal and State regulations. Nursing staff must verify

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medical records to determine whether or not any advance directives have been issued by the resident ...Nursing staff must be aware of other advance directives regarding residents' wishes before certain treatments are initiated (i.e. intravenous feeding). Follow these steps in an emergency situation: If a resident stops breathing or there is an absence of pulse or heat beat, staff will check to determine whether a DNR order has been entered. If there is no DNR order, cardiopulmonary resuscitation (CPR) must be administered immediately. Page 'Code Blue' to summon anyone in the facility who has been certified to administer CPR. At the same time, call emergency paramedic support. The attending physician must also be notified."

A review of the facility policy "Cardiopulmonary Resuscitation (CPR)" revealed, in part, the following: "Policy: Cardiopulmonary Resuscitation (CPR) will be provided to all residents who are identified to be in cardiac arrest unless such resident has a DNR order. Cardiopulmonary resuscitation is performed only by individuals certified in CPR. All licensed nurses are to maintain certification for CPR. Procedure: In the event of cardiac arrest, immediately call for assistance. Two staff members are to verify the current physician order for code status. Use the paging system and call 'Code Blue' to Room Number _____ three times (or location of event). CPR is continued until life support systems are available, or it may be discontinued if: The resident responds. The physician orders CPR to be discontinued. Contact the physician and family. Document the details of occurrence in the medical record using the Code Blue Documentation Form."

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F 155	Continued From page 12 On 6/21/17 at 9:10 a.m., ASM #2, the director of clinical services, presented the survey team with a plan of action related to these concerns. The plan was dated 12/5/16 and documented: - "PROBLEM: Code policy and Procedures. Verification of code status of unresponsive patient. Residents right to self-determination, standards of practice. Step 1 - Evaluation of Systems and Immediate Response. Cardiopulmonary Resuscitation was initiated by the Licensed Nurse and EMS was initiated. Employee suspended until investigation can be completed. Verification of the employee having current CPR certification status by DCS (director of clinical services)/Designee. Completion of grievance form by ED/Designee regarding resident rights followed through the grievance process. Verification by DCS/Designee that crash carts/equipment ready and available. How to Identify other Resident at Risk. Social Service/Designee to contact Residents/RP with full code status and verify continued desire for this status. Review by Social Services Director/Designee of current resident records to ensure that documentation is consistent to include most current MD (medical doctor)/Physician's order...and state DNR document. Review of Licensed Nurse files to verify current CPR certification present. ED (executive director)/Designee to review last (5) in-house deaths to ensure proper following of orders and honoring of resident rights with any concerns to be noted on a grievance form and addressed through the grievance process. What measures were put in place to prevent recurrence? Ongoing staff education by the DCS/Designee on green light/red light with focus on bringing the chart to the code and verifying that the code status is honored. Training by the	F 155		

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DCS/Designee will also focus on upholding resident rights and following Drs. Orders. (sic) Code blue drills will be conducted by the DCS/Designee and ongoing once a week for three months then monthly. ED/SW (social worker)/Designee will continue weekly code status reviews and ensure that status is reviewed at least quarterly with the Resident/RP. Any potential violation of Resident Rights related to code status will be logged/processed through the grievance process. How to monitor to ensure the problem does not reoccur. ED/DCS (director of clinical services) and SW will complete a weekly review of the code drills, code audits and grievance logs to identify any trends or corrective action needed. An impromptu Quality Assurance Performance Improvement Committee Meeting (QAPI) has been held on 12/5/16 to review the POC (plan of correction) and corrective measures. QA. Results of weekly reviews will be reported to the monthly QAPI meeting for review and discussion to ensure substantial compliance by 12/8/16."

The survey team reviewed this plan of action, as well as the credible evidence documenting the implementation of this plan. The survey team identified no concerns related to this implementation. Additionally, the survey team reviewed the CPR licenses of all nursing staff as compared to the as-worked schedules provided by the facility. No concerns were identified related to the facility having CPR-licensed staff on duty at all times in the facility.

This citation is cited as past noncompliance.

"CPR is an emergency procedure for a person whose heart has stopped or is no longer

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F 155	Continued From page 14 breathing. CPR can maintain circulation and breathing until emergency medical help arrives." This information is taken from the website https://medlineplus.gov/cpr.html	F 155	F157 1. The Posey boots were discontinued for resident #2 on 6/22/17. The physician and resident representative were notified of this order at this time. 2. A 100% Quality review of residents with posey boots was completed on 7/13/17 with no additional findings. 3. The policy on physician and resident notification was reviewed and no changes are warranted at this time. Licensed nursing staff will be re-educated on the process of notifying physician and resident representative on or before 7/14/17. 4. The DCS/designee will complete a 100% quality review of all residents with posey boots one time per month. Any negative findings will be corrected immediately and will be reported to the facilities QAPI meeting monthly for 3 months at which time if no further incident is noted it will be monitored intermittently thereafter. 5. Corrective Action will be completed by 7/14/17.	
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 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.			

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(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, facility document review and clinical record review, it was determined that the facility staff failed to notify the physician of a change in clinical status for one of 19 residents in the survey sample, Resident #2.

The facility staff failed to notify the physician when Resident #2 continued to refuse to wear heel protective devices on her bilateral feet for wound prevention.

The findings include:

Resident #2 was admitted to the facility on 4/9/10 with a readmission on 10/31/12 with diagnoses that included, but were not limited to, Parkinson's disease (1), a movement disorder, dementia, dysphagia (difficulty with swallowing), anxiety and depression.

Resident #2's most recent MDS (minimum data set) is a quarterly assessment with an ARD

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(assessment reference date) of 3/29/17. Resident #2 was coded as scoring a three out of a possible 15 on Section C, Cognitive Patterns, BIMS (brief interview for mental status), indicating that Resident #2 is cognitively severely impaired in daily decision making.

A review of Resident #2's clinical record revealed, in part, the following order signed and dated by the nurse practitioner, ASM (administrative staff member) #3, on 10/4/17 (sic). "4/7/17 Posey boots (a heel offloading device worn on the feet to protect the heels from skin breakdown) to bilat (bilateral) feet when in bed.

Further review of Resident #2's clinical record revealed a monthly print out titled "Physician's Orders" that documented, in part, the following order; "5/10/17: Posey boots to bilateral feet when in bed every shift."

A review of Resident #2's physician progress notes revealed, in part, the following; "5/17/17 Assessment and Plan: 1. DTI (deep tissue injury (2)) left heel. The area is now healed. Will continue prevention measures including skin prep and pressure relief foam booties."

Review of Resident #2's facility document "Nurse Tech Information Kardex" (a list of care items to be completed for Resident #2 by CNAs), revealed, the care items "Heel protectors" was not checked to be done.

Resident #2 was observed on 6/21/17 at 8:20 a.m. lying in the bed. LPN (licensed practical nurse) #9 was asked if she could reveal Resident #2's feet under the covers. Permission was obtained from Resident #2 and the nurse lifted

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the covers to reveal that Resident #2 was not wearing booties as ordered.

An interview was conducted with CNA (certified nursing assistant) #5 on 6/21/17 at 10:43 a.m. CNA #5 was asked if she was aware of any wound prevention interventions being done for Resident #2. CNA #5 stated that she was turned every two hours and positioning to prevent wounds. When asked if Resident #2 had any special devices ordered for wound prevention, CNA #5 stated that she was supposed to be wearing boots on her feet, CNA #5 further stated, "They were not on her this morning, she doesn't like them and requests them off." CNA #5 was asked to accompany this writer to Resident #2's room to observe her feet. CNA #5 obtained permission from Resident #2 and uncovered her feet. Resident #2 was not wearing any boots. CNA #5 stated that she didn't even know where the boots were. A hospice aide was beside the bed at the time of the observation and stated that she had not seen the boots for about three weeks. CNA #5 looked in Resident #2's wardrobe and retrieved one boot, CNA #5 stated, "I don't know where the other boot is."

An interview was conducted with LPN (licensed practical nurse) #9 on 6/21/17 at 11:20. LPN #9 was asked what wound prevention devices Resident #2 was supposed to be wearing. LPN #9 stated, "I'm not sure." LPN #9 was shown Resident #2's TAR (treatment administration record). LPN #9 stated, "She is supposed to have booties on her bilateral feet." LPN #9 stated that she had not seen them on Resident #2's feet that morning and she believed that Resident #2 refused to wear them. LPN #9 was asked what the nursing staff should do if Resident #2 was

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refusing to wear the booties. LPN #9 stated that they should circle the date and time the bootie placement was checked on the TAR and circle their initials to indicate refusal and then write a note on the back of the TAR. LPN #9 was asked to review the TAR and asked if there were any notations regarding Resident #2 refusing to wear the booties. LPN #9 stated that there were not. LPN #9 further stated that the physician and RP (responsible party) should be made aware of Resident #2's refusal to wear the bilateral booties. When asked if there was any evidence that the physician or RP had been made aware LPN #9 reviewed the nursing notes and the back of the TAR and stated that it had not been done.

On 6/21/17 at 11:10 a.m. an interview was conducted with LPN #2. LPN #2 was asked when the physician or RP would be notified, LPN #2 stated any time there was a change in condition or a change in therapy. When asked if that included refusal of treatments, LPN #2 stated it did.

A review of Resident #2's comprehensive care plan dated 10/31/12 revealed, in part, the following documentation: "Focus: The resident has the potential for impaired skin integrity r/t (related to) immobility and incontinence. Dated Initiated: 6/23/2016. Interventions: Administer treatments as ordered and monitor for effectiveness. Notify physician for change in condition. Posey boots per order."

On 6/21/17 at 11:45 a.m. a meeting was conducted with ASM (administrative staff member) #1, the administrator and ASM #2, the director of clinical services. ASM #1 and ASM #2 were made aware that the physician and RP had

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F 157	Continued From page 19 not been notified regarding Resident #2's refusal to wear the booties as ordered. ASM #2 was asked if the physician should be notified when a resident refuses a treatment, ASM #2 stated, "Yes." ASM #2 was asked to provide a policy regarding physician notification. No further information was provided prior to the end of the survey process. (1) Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. This information was obtained from the following website: https://medlineplus.gov/parkinsonsdisease.html (2) Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/	F 157		
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (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. §483.10(i) Safe environment. The resident has a	F 252		

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F 252	Continued From page 20 right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (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 document review, it was determined that the facility staff failed to ensure a clean, comfortable, homelike environment on 2 of 2 facility nursing units (Dogwood and Rosewood units) and in 2 of 3 facility shower rooms (small shower room on Rosewood unit and Dogwood shower room). On the Rosewood and Dogwood units, cracks in the tile flooring were observed. In the small shower room on the rosewood unit a black substance was observed on the time. In the Dogwood shower room a black substance was noted on the tile and other debris including hair was observed in the shower stall. The findings include: On 6/21/17 an observation of the facility environment was conducted. The following	F252	1.The floor tiles in the front hall, near room 313 and 341 will be replaced by 7/30/17. The small shower on the Rosewood unit and the shower on the Dogwood unit was scrubbed by Health Care Services using a buffer which resolved the black to light brown residue on floor tile .The bathtub was scrubbed and disinfected eliminating the dirt, hair, plastic bag, white plastic coat hanger, and red shoes on 6/22/17. The dark black substance noted in the grout in the corner tile will be resolved by having the area re-grouted on or before 7/30/17. The lower part of the wall under the handrails with carpet like material will be professionally cleaned by Health care services, the lose/worn edges will be re-attached on or before 7/14/17.	

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concerns were observed:

On the front hallway, from the doors to the lobby, running across the hall to the windows of the dining room was a large crack in the tile of the floor.

On the front hallway, just outside the conference room door, running across the hall from the wall on one side to the wall on the other side was a large crack in the tile of the floor.

On the Rosewood unit, a large crack was running across the tile floor from the doorway of Room 313, straight across the hall to the doorway of Room 319.

On the Rosewood unit, a large crack in the tile floor was running from approximately 3 feet inside of Room 341, across the hall, and approximately 3/4 of the way across the floor of Room 329.

On the Dogwood unit, a large crack in the tile floor was running from the inside window wall of the Recreation Room, across the hall to the wall on the opposite side. One of the tiles near the wall had 2 chips missing as well. One chipped area was approximately 2 to 3 inches x approximately 1/2 inch; and one chipped area was approximately 1/2 inch x 1/2 inch.

On the Rosewood unit, in the smaller of 2 shower rooms, the shower stall was observed to have a light black to brown colored residue on the floor tile.

On the Dogwood unit shower room, there was a light black substance/residue on the floor just outside the shower room door. Inside the shower

2A 100% quality review was conducted of floor tile, shower rooms, bathtubs, and wall coverings on 7/13/17. No additional findings were noted.

3. The maintenance staff and housekeeping staff were educated on 7/14/17 on the proper homelike environment with the policies titled: Maintenance, Maintenance plan, and Hospitality services. A review was conducted of these policies and warranted no change at this time.

4. The Maintenance Director/Designee will perform a quality review once a week: floor tile, shower room's tile and grout, 8athtubs, and wall covering beneath the handrails for cleanliness and dexterity. All negative findings will be corrected immediately and reported once a month at QAPI for 3 months at which time if no further incident is noted it will be monitored intermittently thereafter.

5. Corrective Action will be completed by 7/30/17.

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room, the bathtub was observed to have dirt and hair on the seat, a pair of red rubber shoes on the seat, and down in the tub area was a plastic bag, a white plastic coat hanger, and hair. Inside the shower stall, dark black substance was noted to be in the grout of the corner of the tile wall.

Around the entire facility in all hallways, the lower part of the wall from under the handrail, down to the floor, was covered with a carpet material. This material was noted to contain black and brown stains, scuff marks, discoloration, worn surface areas, and worn or loose edges throughout the facility.

On 6/21/17 at 11:05 a.m., OSM #2 (Other Staff Member), the Maintenance Director, was shown all the above areas of concerns. He stated that, regarding the tile flooring issues, the cement slab underneath contains expansion joints, and the movement of those joints over time causes the tile on top to crack, chip, and buckle over time. He stated this mostly happens in areas where the tile floor seams were not properly installed in line with the expansion joints, which he said would minimize the cracking issues.

On 6/21/17 at 11:35 a.m., OSM #2 and OSM #3 (Housekeeping Services Manager) provided policies regarding the above identified concerns. OSM #3 stated that, regarding the cleaning of the shower rooms, that nursing staff are to report any concerns they see to housekeeping. She stated that when housekeeping is cleaning these rooms, if they see anything, they are to take care of it immediately. She stated that the shower rooms are scrubbed weekly and as needed. She stated the carpeted walls in the hallways are cleaned with a disinfectant and microfiber cloth routinely.

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F 252	Continued From page 23 On 6/21/17 at 11:38 a.m., OSM #2 stated that during daily morning meetings, housekeeping and maintenance issues are discussed; and that there is a daily evening meeting as well wherein the issues are readdressed and updated about what has been completed. A review of the facility policy, "Maintenance" documented, "The Director of Environmental Services will perform daily rounds of the building to ensure the plant is free of hazards and in proper physical condition." A review of the facility policy, "Maintenance Plan" documented, "All equipment and furnishings will be maintained in good condition. When a staff member notices an item needing repair, he/she will complete a work order request defining the area or item needing repair. The maintenance staff will review the log and make the appropriate repairs which may include:...Floor and Carpet care..." A review of the facility policy, "Hospitality Services" documented, "Standards for routine cleaning of all interior spaces will be followed, including, but not limited to patient rooms, patient and public baths, tub and shower rooms, closets, utility rooms, offices, diet kitchens, storage spaces, TV and sitting rooms...." On 6//21/17 at 11:50 a.m., the Administrator and Director of Nursing (ASM (Administrative Staff Member) #1 and #2) were made aware of the findings. No further information was provided.	F 252		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	Continued From page 24 (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, facility staff interview, staff interview, and clinical record review, it was determined that the facility staff failed to follow the written plan of care for two of 26 residents in the survey sample, Residents #10 and #8. 1. The facility staff failed to implement an air mattress per the written plan of care for Resident #10. 2. The facility staff failed to maintain the bed in a low position, as directed in Resident #8's comprehensive care plan, to promote safety. The findings include: 1. Resident #10 was admitted to the facility on 5/4/15 and most recently readmitted on 3/31/16 with diagnoses including, but not limited to: intellectual disability, enlarged prostate, Parkinson's disease, and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment dated 3/15/17, he was coded as being cognitively intact for making daily decisions. He was not coded as having any pressure ulcers. On the following dates, Resident #10 was	F 282	1. A physicians order was obtained on 6/21/17 to discontinue the air mattress for resident #10 and the care plan was updated on 6/22/2017. A Physicians order was obtained on 6/26/17 to discontinue the low bed for resident # 8 and the care plan was updated at that time. 2. A 100% quality review was completed on 7/13/2017 of all residents with physician orders for air mattresses and low beds. No additional findings were noted. 3. A review was conducted of the policy entitled "Plans of Care" and no changes are warranted at this time. Nursing staff were re-educated on this policy on or before 7/14/17. 4. The DCS/designee will complete a 100% quality review of all residents with low beds and air mattresses one time per month. Any negative findings will be corrected immediately and will be reported to the facilities QAPI meeting monthly for 3 months at which time if no further incident is noted it will be monitored intermittently thereafter. 5. Corrective Action will be completed by 7/14/17.	

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observed in bed, with a regular pressure-reducing mattress on the bed: 6/19/17 at 6:25 p.m.; 6/20/17 at 7:45 a.m.; and 6/21 17 at 6:55 a.m.

A review of the physician's orders revealed, in part, the following: "Air mattress every shift." The order was written on 5/18/16 and was most recently signed by the nurse practitioner on 6/12/17.

A review of the TAR (treatment administration record) for Resident #10 for June 2017 revealed that the air mattress was signed off as being in place each shift during the month of June.

A review of Resident #10's comprehensive care plan dated 3/6/16 and updated on 9/21/16 revealed, in part, the following: "Air mattress per order."

On 6/21/17 at 9:55 a.m., LPN (licensed practical nurse) #2 accompanied the surveyor to Resident #10's room. When asked what kind of mattress was on Resident #10's bed, LPN #2 stated: "I'm not sure the exact kind." When asked if the mattress was an air mattress, LPN #2 stated: "No. It's definitely not an air mattress." LPN #2 stated she needed to check Resident #10's chart because she was not certain that the order for the air mattress was correct.

On 6/21/17 at 10:20 a.m., LPN #2 and ASM (administrative staff member) #2, the director of clinical services, were interviewed. ASM #2 stated: "You are right. [The air mattress] is on the TAR. I'm looking to see if there was ever an order to discontinue it [the air mattress] that was not ever transcribed." LPN #2 stated: "If it's ordered, it should be on there." When asked how

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she makes sure that she follows a resident's care plan, LPN #2 stated: "To be honest, I don't really look at the care plan every day. I really only do that if I have a question." When asked if a resident's plan of care should be followed, LPN #2 stated: "Yes."

On 6/21/17 at 10:40 a.m., ASM #2 stated: "I can't find the order to discontinue [the air mattress]. It should have been on the bed." ASM #2 was asked to provide a copy of the facility's policy regarding following care plans. She stated: "I'm not sure if we have one. I will look and give you one if I can find it."

On 6/21/17 at 10:45 a.m., ASM #1, the executive director, was informed of this concern.

No further information was provided prior to exit.

2) The facility staff failed to maintain Resident #8's bed in a low position, as directed in Resident #8's written plan of care.

Resident #8 was admitted to the facility on 4/21/17 with diagnoses that included, but were not limited to, the following diagnoses; anemia (low red blood cell count), seizures, alcohol dependence with withdrawal.

Resident #8's most recent MDS (minimum data set) is an admission assessment with an ARD (assessment reference date) of 4/28/17. Resident #8 was coded as scoring 12 out of a possible 15 on the BIMS (brief interview of mental status) in Section C, Cognitive Patterns,

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indicating that Resident #8 is cognitively intact with daily decision making.

A review of Resident #8's clinical record revealed a physician order dated 4/24/17 that documented, in part, the following; "4/24/17: Bed to be in low position while resident in the bed."

A review of Resident #8's comprehensive care plan dated 4/21/17 revealed, in part, the following documentation; "Focus: The resident has the potential for injury r/t (related to) recurrent falls, ETOH (ethyl alcohol) abuse, dx (diagnoses) of seizures, anxiety, non-compliant with ringing call bell, impaired insight, judgement and safety awareness, behaviors and debility. Date Initiated: 5/2/17. Revision on 5/9/17. Interventions: Bed in low position. Date Initiated 5/2/2017."

A review of Resident #8's facility document "Nurse Tech (technician) Information Kardex (a tool to provide direction to aides caring for residents)" revealed, in part, the following documentation; "Safety: Other: Low bed."

Resident #8 was observed lying in his bed on four occasions during the survey process; 6/19/17 at 8:20 p.m., 6/20/17 at 7:45 a.m., 6/20/17 at 12:00 p.m. and 6/21/17 at 7:30 a.m. Each observation revealed that Resident #8's bed was not low and was at a regular height.

On 6/21/17 at 10:20 a.m. an interview was conducted with CNA (certified nursing assistant) #6. CNA #6 was asked how she was provided information on the care needs of the residents she was caring for. CNA #6 stated, "We have the Kardex that helps us to know what special needs there are. Nursing updates the Kardex." CNA #6

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was asked if the Kardex followed the resident's care plan. CNA #6 stated that it did. CNA #6 was asked to review Resident #8's Kardex and asked what she was supposed to do for Resident #8 to ensure safety from falls. CNA #6 stated, "He did have fall preventions when he was first admitted, but not anymore." CNA #6 was asked whether or not Resident #8 was to be in a low bed, CNA #6 stated, "No. It was discontinued." CNA #6 was asked who discontinued the order for the low bed. CNA #6 stated, "I couldn't say, it would have had to have been the doctor or nurse practitioner."

On 6/21/17 at 10:30 a.m. an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 was asked what safety preventative measures were in place for Resident #8. LPN #6 stated, "None, they were all taken away." LPN #6 was asked specifically about the order for the low bed. LPN #6 stated, "It was discontinued, fairly recently." LPN #6 was asked to review Resident #8's clinical record and demonstrate where the low bed was discontinued. LPN #6 stated, "We do not have an order to discontinue the low bed. We have not been maintaining a low bed. He is doing so well." LPN #6 was asked the purpose of the care plan. LPN #6 stated the care plan was to direct the care specific to a resident. LPN #6 was shown Resident #8's care plan for safety and the documentation for, "Bed in low position." LPN #6 stated, "(Name of Resident #8's) care plan does not reflect the care we are currently providing. When asked if the care should follow the care plan, LPN #6 stated, "Yes it should. We haven't been doing it. The low bed should still be in place and he has not been on a low bed."

On 6/21/17 at 11:45 a.m. a meeting was conducted with ASM (administrative staff

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F 282	Continued From page 29 member) #1, the administrator and ASM #2, the director of clinical services. ASM #1 and ASM #2 were made aware that the nursing staff had not been following the written plan of care for Resident #8. His bed was not being kept in the low position when he was in the bed. A policy was requested at this time regarding following the care plan. The facility document titled, "Plans of Care" revealed, in part, the following documentation; "Policy: An interdisciplinary plan of care will be established for each resident and updated in accordance with state and federal regulatory requirements and on an as needed bases. Procedure: Direct care staff should be aware, understand and follow their Resident's Plan of Care." No further information was provided prior to the end of the survey process.	F 282		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 309		

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F 309	Continued From page 30 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed staff failed to provide care and services to promote the highest level of well-being for one of 19 residents in the survey sample, Residents #14. Resident #14 had signed an advance directive stating she wanted all resuscitative efforts to be undertaken for her. In accordance with this advance directive, the physician had written an order that the resident would be a full code. On 12/4/17, Resident #14 was discovered to be without pulse and without respirations. The facility staff failed to honor the advance directive and failed to follow the physician's order by immediately beginning CPR and calling for	F 309	Past noncompliance: no plan of correction required.	

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emergency medical assistance and Resident #14 expired.

The findings include:

Resident #14 was admitted to the facility on 11/24/16 with diagnoses including, but not limited to: ovarian cancer which had spread, diabetes, nausea, and vomiting. On the most recent MDS (minimum data set), an admission assessment with an assessment reference date of 12/1/16, Resident #14 was coded as being severely cognitively impaired for making daily decisions, having scored only three out of 15 on the BIMS (brief interview for mental status).

A review of the admission nursing assessment dated 11/24/16 revealed that Resident #14 was alert and oriented to person only.

A review of Resident #14's clinical record revealed a page with the title "FIRST ALERT." This page contained the following: "CODE ALERT: FULL."

Further review of the clinical record revealed the document "[Name of state] Advance Directive for Health Care." This document stated, in part: "I [name Resident #14] willingly and voluntarily make known my wishes in the event that I am incapable of making an informed decision about my health care, as follows:...Section II: My Health Care Instructions...I provide the following instructions in the event my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover...I want all treatments to prolong my life as long as possible within the limits of generally accepted

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health care standards. I understand that I will receive treatment to relieve pain and make me comfortable." This document listed the names of one individual to serve as primary agent, and another individual to serve as secondary agent. This document was signed by Resident #14 and dated 11/22/16.

Further review of the clinical record revealed a document with the title "Advance Directives Discussion Document." The document stated, in part: "Please indicate your wishes regarding the following: Cardiopulmonary Resuscitation (CPR): PROVIDE. Please indicate if you possess any of the following documents or have primary decision-maker." The document contained a check mark beside the categories of advance directive and health care agent. The document continued: "I have received a copy of the facility's policies on Advance Directives and have been given a chance to ask questions regarding my rights to make decisions regarding my medical care. I understand that I have the right to refuse or accept medical and/or surgical treatment, and the right to formulate advance directives concerning my health care. Honoring resident choices requires providing appropriate documentation, and I understand that I am responsible for providing the facility with the necessary and/or legal documentation appropriate for Advance Directives." The document was signed by Resident #14 and by the primary agent designated in the Advance Directive for Health Care.

A review of the physician's orders for Resident #14 revealed the following order, dated 11/24/16 and signed by the physician on 12/1/16: "Code - full."

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A review of Resident #14's comprehensive care plan dated 11/24/16 revealed no information related to her advance directive or code status.

A review of the nurses' notes for Resident #14 revealed, in part, the following:
- 12/3/16 - 12/4/16 "7p - 7a (7:00 p.m. on 12/3/16 through 7:00 a.m. on 12/4/16) - Resident resting quietly. [Arrow pointing up] (increased) temp (body temperature). No c/o (complaint of) pain. No SOB (shortness of breath)/cough noted. Call bell in reach. Will cont (continue) to monitor.
- @ (at) 130 (1:30 a.m.), CNA (certified nursing assistant) went into take resident's temp and found her with no pulse and not breathing. Blue around lips and nail beds. ADCS (assistant director of clinical services [*note at the time of this incident the current director of clinical services, administrative staff member #2, held the position of assistant director of clinical services]) and Dr. (doctor) notified." Both of these notes were signed by LPN (licensed practical nurse) #10.
- "12/4/16 0245 (2:45 a.m.) Pt (patient) without respiration, no apical heart rate present. Pt (patient) expired, pt identified as full code @ this time. 2nd (second) nurse verified. CPR initiated. EMS (emergency medical services) called. MD (medical doctor [physician]) made aware and RP (responsible party)." This note was signed by ASM (administrative staff member) #2, the director of clinical services.

Further review of the clinical record revealed the following order, dated 12/4/16 and was signed by ASM #3, the nurse practitioner, on 12/7/16: "Send to ER (emergency room) for eval (evaluation) and treat (treatment)."

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A review of the EMS (Emergency Medical Service) record for Resident #14 dated 12/4/16 revealed, in part, the following: "Dispatched to [facility] for a person in cardiac arrest. On scene, in [Resident #14's room number], found a 72 YOF (year old female) lying supine on the bed with staff performing CPR on the pt and was (sic) bagging her with bi-valve mask. Staff was asked if there were a DNR (do not resuscitate) and they advised that she is a full code. Pt was found in cardiac arrest while the nurse was doing rounds. Unknown down time. CPR was started and 911 called. General impression was poor. Pt was unresponsive. Pt was not mobile. Pt was unstable. Pt was logged rolled (sic) onto a backboard and the Lucas device (automatic CPR machine) was place and was initiated to take over CPR. Care was transferred to [name of EMS company]. Medical hx (history) was obtained from staff. Pt allergies are unknown...Pt was picked up and carried out to the cot and placed on it and secured...Pt had no signs of life. Pt was transported to [name of local hospital]...On arrival to [name of local hospital], pt was still unresponsive and not breathing."

A review of the records from the local hospital dated 12/4/16 revealed, in part, the following: "Emergency History and Physical Exam: "[Name of Resident #14] is a 72 y.o. (year old) female who presents by EMS. Apparently the patient was found on the floor unresponsive in (sic) cyanotic around at the nursing home...unknown how long she had been down...Differential diagnosis considered includes: Dead on arrival...The patient was pronounced dead at 3:43 a.m. Death certificate completed. Clinical Impression: Dead on arrival."

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A review of the report sent to the state agency dated 12/6/16 revealed, in part, the following: "[Name of Resident #14] was a 72 year old female admitted to this facility on 11/24/16...Her advanced directive requested full code status. On 12/4/16 at 0130 (1:30 a.m.), [Resident #14] presented as unresponsive to the on shift CNA. The CNA reported this to LPN Charge Nurse [name of LPN #10], who noted the resident as having no pulse, no breathing and presenting with blue lips and nail beds. [LPN #10] phoned [ASM #2] and requested that she come to the facility and pronounce death. On arrival, [ASM #2] also noted [Resident #14] to be absent of vital signs; but identified [Resident #14] as a full code and initiated the facility CPR policy and transferred [Resident #14] via EMS to the local emergency department...After facility investigation, neglect has been substantiated. [LPN #10's] employment with this facility has been terminated and required reporting will occur to the Department of Health Professions."

A review of the facility's investigation file about this incident revealed the following statement written by LPN #3 and dated 12/5/16: "On December 4, 2016, [LPN #10] asked me to come and check patient with her. Listened to heart and lungs nothing heard (sic). [LPN #10] was nonchalant with the situation told (sic) me patient had been declining and had hx (history) of CA (cancer). This lead (sic) me to believe that the patient was comfort and expecting to go any time."

Further review of the facility's investigation file revealed the following statement written by LPN #10 dated 12/4/16: "At 0130 (1:30 a.m.) I sent

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CNA to take temp of resident. Earlier she had a temp of 100.1. CNA called me to the resident's room. Found resident without resp (respirations) and very pale and turning cold. (Resident had been checked on an hour prior.) At this point I called another nurse to listen for heart rate/breath sounds. At this point I texted the ADCS (assistant director of clinical services) and left a message and she returned the called (sic). At this point, I was unaware the resident was a full code. When the ADCS arrived we began CPR and called the squad (EMS)."

On 6/20/17 at 1:45 p.m., LPN #5 was interviewed. When asked what she would do if a staff member reported to her that a resident under her care had been found without pulse and without respirations, LPN #5 stated: "I would page a code blue." She stated the process is for two nurses to check the resident's chart and clarify the physician's order. If the resident is a full code, "somebody starts CPR and somebody else makes the calls and does the paperwork." She stated the facility provides frequent training and code blue drills for the staff.

On 6/20/17 at 2:40 p.m., LPN #4 was interviewed. When asked what she would do if a staff member reported to her that a resident under her care had been found without pulse and without respirations, LPN #4 stated: "I would grab the chart to see whether or not they are a DNR." She stated if the resident was not a DNR, she would assess the resident and start CPR if there were no vital signs. She stated she would get other staff members to call the rescue squad, family, and physician.

On 6/20/17 at 3:40 p.m., ASM #3, the nurse

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practitioner, was interviewed. When asked if a resident has an order to be a full code, and if that resident ceased heart rate and respirations, what should be done, ASM #3 stated: "The resident should be coded." ASM #3 stated: "The underlying diagnosis doesn't matter. If it's the middle of the night and the resident is a full code, we must start CPR and call 911." She added that she is aware that the facility practices this scenario by way of code blue drills frequently.

On 6/21/17 at 7:05 a.m., CNA #1 was interviewed. She stated that she was assigned to Resident #14 on the night of 12/3/16 through 12/4/16. She stated the resident had a fever earlier in the shift, and that LPN #10 had asked her to re-check the resident's temperature. CNA #1 stated when she entered the resident's room, "it looked like she was dead. She was gray." She stated she stepped out of the room and called for LPN #10 to come to the room. CNA #1 stated: "[LPN #10] never looked at the chart. She immediately yelled for LPN #3 to come and help her. They both went in the room and checked [Resident #14]." She stated she remembered the nurses talking to each other about who was on call for the facility to pronounce death, and that neither of them discussed the resident's code status. She stated one of the nurses called ASM #2, the director of clinical services and that it was "a good while" before ASM #2 arrived at the facility. CNA #1 stated ASM #2 "came in and pronounced [Resident #14's death]." She stated ASM #2 went to do paperwork at the desk, and discovered that Resident #14 was a full code. CNA #1 stated ASM #2 started CPR and other staff called emergency services.

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On 6/21/17 at 7:10 a.m., LPN #3 was interviewed. LPN #3 stated: "I was working on my side and [LPN #10] yelled for me to go help her. We went in the room. [Resident #14] was gray and cold. [LPN #10] told me the resident had cancer, and had been declining. She told me the resident had basically given up. I thought she was on comfort care. We both assessed her." LPN #3 stated there were no signs of life, and there was no discussion of the resident's code status. LPN #3 stated LPN #10 called ASM #2. ASM #2 arrived at the facility and "they started CPR. I really don't know what happened after that because I went back to work on my side."

On 6/21/17 at 7:20 a.m., ASM #2, (the director of clinical services [who at the time of this incident was in the position of assistant director of clinical services]) was interviewed. ASM #2 stated during the early morning hours of 12/4/16, she received a call from LPN #10. She did not remember the exact time, and stated LPN #10 left a voicemail for her. ASM #2 stated: "At some point I woke up and checked the voicemail. I came in, went in the room. I observed [Resident #14] was not breathing, no pulse, and no blood pressure. I went down to the desk and started to write the note and saw the green spine on the chart." ASM #2 stated a green spine indicates that a resident has a physician's order for a full code. She stated when she checked the chart for the physician's order, she discovered that Resident #14 was a full code, and she went and "started CPR on her (Resident #14)." ASM #2 stated the EMS arrived, took over the CPR and transported the resident to the emergency room. She stated she called ASM #4, the attending physician, later in the morning and told him what had happened.

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On 6/21/17 at 7:35 a.m., ASM #4 was interviewed. He stated he did not remember being called by LPN #10 to inform him that Resident #14 had been discovered in her room without signs of life. He stated he remembered ASM #2 calling him later to inform him of what had happened. When asked what process was to be followed when a resident who has a full code order is discovered without signs of life, ASM #4 stated: "We should immediately call a code and call 911, and we should immediately begin resuscitative efforts."

The administrator and director of nursing at the time of this incident are no longer employed by the facility.

On 6/21/17 at 8:35 a.m., ASM #1, the executive director, and ASM #2 were informed of these concerns. At this time, the survey team informed these staff members of the concern for harm.

A review of the facility policy "Advance Directives - Nursing" revealed, in part, the following: "The facility nursing staff will abide by resident advance-directives, if known, and if those directives are not in conflict with Federal and State regulations. Nursing staff must verify medical records to determine whether or not any advance directives have been issued by the resident ...Nursing staff must be aware of other advance directives regarding residents' wishes before certain treatments are initiated (i.e. intravenous feeding). Follow these steps in an emergency situation: If a resident stops breathing or there is an absence of pulse or heat beat, staff will check to determine whether a DNR order has been entered. If there is no DNR order, cardiopulmonary resuscitation (CPR) must be

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administered immediately. Page 'Code Blue' to summon anyone in the facility who has been certified to administer CPR. At the same time, call emergency paramedic support. The attending physician must also be notified."

A review of the facility policy "Cardiopulmonary Resuscitation (CPR)" revealed, in part, the following: "Policy: Cardiopulmonary Resuscitation (CPR) will be provided to all residents who are identified to be in cardiac arrest unless such resident has a DNR order. Cardiopulmonary resuscitation is performed only by individuals certified in CPR. All licensed nurses are to maintain certification for CPR. Procedure: In the event of cardiac arrest, immediately call for assistance. Two staff members are to verify the current physician order for code status. Use the paging system and call 'Code Blue' to Room Number _____ three times (or location of event). CPR is continued until life support systems are available, or it may be discontinued if: The resident responds. The physician orders CPR to be discontinued. Contact the physician and family. Document the details of occurrence in the medical record using the Code Blue Documentation Form."

On 6/21/17 at 9:10 a.m., ASM #2, the director of clinical services, presented the survey team with a plan of action related to these concerns. The plan was dated 12/5/16 and documented:
- "PROBLEM: Code policy and Procedures. Verification of code status of unresponsive patient. Residents right to self-determination, standards of practice. Step 1 - Evaluation of Systems and Immediate Response. Cardiopulmonary Resuscitation was initiated by the Licensed Nurse and EMS was initiated.

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Employee suspended until investigation can be completed. Verification of the employee having current CPR certification status by DCS (director of clinical services)/Designee. Completion of grievance form by ED/Designee regarding resident rights followed through the grievance process. Verification by DCS/Designee that crash carts/equipment ready and available. How to Identify other Resident at Risk. Social Service/Designee to contact Residents/RP with full code status and verify continued desire for this status. Review by Social Services Director/Designee of current resident records to ensure that documentation is consistent to include most current MD (medical doctor)/Physician's order...and state DNR document. Review of Licensed Nurse files to verify current CPR certification present. ED (executive director)/Designee to review last (5) in-house deaths to ensure proper following of orders and honoring of resident rights with any concerns to be noted on a grievance form and addressed through the grievance process. What measures were put in place to prevent recurrence? Ongoing staff education by the DCS/Designee on green light/red light with focus on bringing the chart to the code and verifying that the code status is honored. Training by the DCS/Designee will also focus on upholding resident rights and following Drs. Orders. (sic) Code blue drills will be conducted by the DCS/Designee and ongoing once a week for three months then monthly. ED/SW (social worker)/Designee will continue weekly code status reviews and ensure that status is reviewed at least quarterly with the Resident/RP. Any potential violation of Resident Rights related to code status will be logged/processed through the grievance process. How to monitor to ensure the

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F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the	F 314		

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comprehensive assessment of a resident, the facility must ensure that-

(i) A resident receives care, consistent with 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 document review and clinical record review, it was determined that the facility staff failed to implement interventions to prevent pressure ulcers for two of 19 residents in the survey sample, Resident #2 and Resident #10.

1. The facility staff failed to place protective boots on Resident #2's bilateral feet to prevent skin breakdown on her heels as ordered by the physician.

2. The facility staff failed to provide Resident #10 with a physician-ordered air mattress.

The findings include:

1. The facility staff failed to place heel protector boots on Resident #2's bilateral feet to prevent skin breakdown on her heels as ordered by the physician.

Resident #2 was admitted to the facility on 4/9/10

1. . The Posey boots were discontinued for resident #2 on 6/22/17 and the care plan was updated at that time. A physicians order was obtained on 6/21/17 to discontinue the air mattress for resident #10 and the care plan was updated on 6/22/17.

2. A 100% quality review was completed on 7/13/17 of all residents with physician orders for air mattresses and Posey boots. No additional findings were noted.

3. A review was conducted of the policies entitled "Nurse tech information Kardex" and "Clinical Guideline Skin and Wound" and no changes are warranted at this time. Nursing staff were re-educated on this policy on or before 7/14/17.

4. The DCS/designee will complete a 100% quality review of all residents with Posey boots and air mattresses one time per month. Any negative findings will be corrected immediately and will be reported to the facilities QAPI meeting monthly for 3 months at which time if no further incident is noted it will be monitored intermittently thereafter.

5. Corrective Action will be completed by 7/14/17.

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with a readmission on 10/31/12 with diagnoses that included, but were not limited to, Parkinson's disease (1), a movement disorder, dementia, dysphagia (difficulty with swallowing), anxiety and depression.

Resident #2's most recent MDS (minimum data set) is a quarterly assessment with an ARD (assessment reference date) of 3/29/17. Resident #2 was coded as scoring a three out of a possible 15 on Section C, Cognitive Patterns, BIMS (brief interview for mental status), indicating that Resident #2 is cognitively severely impaired in daily decision making. Section M, Skin Conditions, did not reveal any wounds coded on this MDS assessment.

A review of Resident #2's clinical record revealed, in part, the following order signed and dated by the nurse practitioner, ASM (administrative staff member) #3, on 10/4/17 (sic). "4/7/17 Posey boots (a heel offloading device worn on the feet to protect the heels from skin breakdown) to bilat (bilateral) feet when in bed.

Further review of Resident #2's clinical record revealed a monthly print out titled "Physician's Orders" that documented, in part, the following order; "5/10/17: Posey boots to bilateral feet when in bed every shift."

A review of Resident #2's physician progress notes revealed, in part, the following; "5/17/17 Assessment and Plan: 1. DTI (2) (deep tissue injury) left heel. The area is now healed. Will continue prevention measures including skin prep and pressure relief foam booties."

Review of Resident #2's facility document "Nurse

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Tech Information Kardex" (a list of care items to be completed for Resident #2 by CNAs), revealed, the care items "Heel protectors" was not checked to be done.

A review of Resident #2's June 2017 TAR (treatment administration record) revealed, in part, the following documentation: "5/10/17. Posey Boots to bilateral feet when in bed every shift. 7a (a.m.) - 7p (p.m.) 7p (p.m.) - 7a (a.m.)." Nursing initials were entered for each date and each shift. 6/21/17 did not contain any initials.

A review of Resident #2's nursing notes revealed, in part, the following documentation; "6/5/17 Heel boots on left foot."

A review of Resident #2's comprehensive care plan dated 10/31/12 revealed, in part, the following documentation: "Focus: The resident has the potential for impaired skin integrity r/t (related to) immobility and incontinence. Dated Initiated: 6/23/2016. Interventions: Administer treatments as ordered and monitor for effectiveness. Notify physician for change in condition. Posey boots per order."

Resident #2 was observed on 6/21/17 at 8:20 a.m. lying in the bed. LPN #9 (licensed practical nurse) was asked if she could reveal Resident #2's feet under the covers. Permission was obtained from Resident #2 and the nurse lifted the covers to reveal that Resident #2 was not wearing booties as ordered.

An interview was conducted with CNA (certified nursing assistant) #5 on 6/21/17 at 10:43 a.m. CNA #5 was asked if she was aware of any wound prevention interventions being done for

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Resident #2. CNA #5 stated that she was turned every two hours and positioning to prevent wounds. When asked if Resident #2 had any special devices ordered for wound prevention, CNA #5 stated that she was supposed to be wearing boots on her feet, CNA #5 further stated, "They were not on her this morning, she doesn't like them and requests them off." CNA #5 was asked to accompany this writer to Resident #2's room to observe her feet. CNA #5 obtained permission from Resident #2 and uncovered her feet. Resident #2 was not wearing any boots. CNA #5 stated that she didn't even know where the boots were. A hospice aide was beside the bed at the time of the observation and stated that she had not seen the boots for about three weeks. CNA #5 looked in Resident #2's wardrobe and retrieved one boot, CNA #5 stated, "I don't know where the other boot is."

An interview was conducted with LPN (licensed practical nurse) #9 on 6/21/17 at 11:20. LPN #9 was asked what wound prevention devices Resident #2 was supposed to be wearing. LPN #9 stated, "I'm not sure." LPN #9 was shown Resident #9's June 2017 TAR (treatment administration record). LPN #9 stated, "She is supposed to have booties on her bilateral feet." LPN #9 stated that she had not seen them on Resident #2's feet that morning and that she believed that Resident #2 refused to wear them. LPN #9 was asked what the nursing staff should do if Resident #2 was refusing to wear the booties. LPN #9 stated that they should circle the date and time the bootie placement was checked on the TAR and circle their initials to indicate refusal and then write a note on the back of the TAR. LPN #9 was asked to review the TAR and asked if there were any notations regarding

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F 314	Continued From page 47 Resident #2 refusing to wear the booties. LPN #9 stated that there were not. On 6/21/17 at 11:45 a.m. a meeting was conducted with ASM #1, the administrator and ASM #2, the director of clinical services. ASM #1 and ASM #2 were made aware that the facility staff did not place booties on Resident #2's feet as ordered that morning. ASM #2 was asked if heel protection boots were necessary to prevent breakdown to Resident #2's heels. ASM #2 stated "Yes." ASM #2 was asked to provide a policy regarding wound prevention. No further information was provided prior to the end of the survey process. (1) Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. This information was obtained from the following website: https://medlineplus.gov/parkinsonsdisease.html (2) Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ 2. The facility staff failed to provide an air	F 314		

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mattress per physician's order for Resident #10.

Resident #10 was admitted to the facility on 5/4/15 and most recently readmitted on 3/31/16 with diagnoses including, but not limited to: intellectual disability, enlarged prostate, Parkinson's disease, and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment dated 3/15/17, he was coded as being cognitively intact for making daily decisions. He was not coded as having any pressure ulcers.

On the following dates, Resident #10 was observed in bed, with a regular pressure-reducing mattress on the bed: 6/19/17 at 6:25 p.m.; 6/20/17 at 7:45 a.m.; and 6/21 17 at 6:55 a.m.

A review of the physician's orders revealed, in part, the following: "Air mattress every shift." The order was written on 5/18/16 and was most recently signed by the nurse practitioner on 6/12/17.

A review of the TAR (treatment administration record) for Resident #10 for June 2017 revealed that the air mattress was signed off as being in place each shift during the month.

A review of Resident #10's comprehensive care plan dated 3/6/16 and updated on 9/21/16 revealed, in part, the following: "Air mattress per order."

On 6/21/17 at 9:55 a.m., LPN (licensed practical nurse) #2 accompanied the surveyor to Resident #10's room. When asked what kind of mattress was on Resident #10's bed, LPN #2 stated: "I'm not sure the exact kind." When asked if the

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mattress is an air mattress, LPN #2 stated: "No. It's definitely not an air mattress." LPN #2 stated she needed to check Resident #10's chart because she was not certain that the order for the air mattress was correct.

On 6/21/17 at 10:20 a.m., LPN #2 and ASM (administrative staff member) #2, the director of clinical services, were interviewed. ASM #2 stated: "You are right. [The air mattress] is on the TAR. I'm looking to see if there was ever an order to discontinue it [air mattress] that was not ever transcribed." LPN #2 stated: "If it's ordered, it should be on there."

On 6/21/17 at 10:40 a.m., ASM #2 stated: "I can't find the order to discontinue [the air mattress]. It should have been on the bed."

On 6/21/17 at 10:45 a.m., ASM #1, the executive director, was informed of this concern.

A review of the facility policy "Clinical Guideline - Skin and Wound" revealed, in part, the following: "Overview: To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing, and decrease worsening of/prevention of pressure injury...Develop individualized goals and interventions and document in the medical record...Evaluate the effectiveness of interventions, and progress towards goals during the care management meeting and as needed."

No further information was provided prior to exit.

In Fundamentals of Nursing, 6th edition, 2005, Patricia A. Potter and Anne Griffin Perry; Mosby,

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F 314	Continued From page 50 Inc., Page 419: "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."	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. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to	F 323		

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implement safety interventions for one of 19 residents in the survey sample, Resident #8.

The facility staff failed to maintain Resident #8's bed in a low position as a safety measure following a fall, as ordered by the physician.

The findings include;

Resident #8 was admitted to the facility on 4/21/17 with diagnoses that included, but not limited to, the following diagnoses; anemia (low red blood cell count), seizures, alcohol dependence with withdrawal.

Resident #8's most recent MDS (minimum data set) is an admission assessment with an ARD (assessment reference date) of 4/28/17. Resident #8 is coded as scoring 12 out of a possible 15 on the BIMS (brief interview of mental status) in Section C, Cognitive Patterns, indicating that Resident #8 is cognitively intact with daily decision making.

A review of Resident #8's clinical record revealed that Resident #8 had fallen in the facility on two occasions, 5/8/17 (a fall from his wheelchair) and 5/12/17 (a fall out of bed). There were no injuries associated with either fall.

A review of Resident #8's clinical record revealed a physician order dated 4/24/17 that documented, in part, the following; "4/24/17: Bed to be in low position while resident in the bed."

A review of Resident #8's comprehensive care plan dated 4/21/17 revealed, in part, the following documentation; "Focus: The resident has the potential for injury r/t (related to) recurrent falls,

1. A Physicians order was obtained on 6/26/17 to discontinue the low bed for resident # 8 and the care plan was updated at that time.

2. A 100% quality review was completed on 7/13/2017 of all residents with physician orders for low beds. No additional findings were noted.

3. A review was conducted of the policy entitled "Plans of Care" and no changes are warranted at this time. Nursing staff were re-educated on this policy on or before 7/14/17.

4. The DCS/designee will complete a 100% quality review of all residents with low beds one time per month. Any negative findings will be corrected immediately and will be reported to the facilities QAPI meeting monthly for 3 months at which time if no further incident is noted it will be monitored intermittently thereafter.

5. Corrective Action will be completed by 7/14/17.

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ETOH (ethyl alcohol) abuse, dx (diagnosis of seizures, anxiety, non-compliant with ringing call bell, impaired insight, judgement and safety awareness, behaviors and debility. Date Initiated: 5/2/17. Revision on 5/9/17. Interventions: Bed in low position. Date Initiated 5/2/2017."

A review of Resident #8's facility document "Nurse Tech (technician) Information Kardex (a tool to provide direction to aides caring for residents)" revealed, in part, the following documentation; "Safety: Other: Low bed."

Resident #8 was observed lying in his bed on four occasions during the survey process; 6/19/17 at 8:20 p.m., 6/20/17 at 7:45 a.m., 6/20/17 at 12:00 p.m. and 6/21/17 at 7:30 a.m. Each observation revealed that Resident #8's bed was not low and was at a regular height.

On 6/21/17 at 10:20 a.m. an interview was conducted with CNA (certified nursing assistant) #6. CNA #6 was asked how she was provided information on the care needs of the residents she was caring for. CNA #6 stated, "We have the Kardex that helps us to know what special needs there are. Nursing updates the Kardex." CNA #6 was asked if the Kardex followed the resident's care plan. CNA #6 stated that it did. CNA #6 was asked to review Resident #8's Kardex and asked what she was supposed to do for Resident #8 to ensure safety from falls. CNA #6 stated, "He did have fall preventions when he was first admitted, but not anymore." CNA #6 was asked whether or not Resident #8's bed was to be in a low position, CNA #6 stated, "No. It was discontinued." CNA #6 was asked who discontinued the order for the low bed. CNA #6 stated, "I couldn't say, it would have had to have been the doctor or nurse

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practitioner."

On 6/21/17 at 10:30 a.m. an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 was asked what safety preventative measures were in place for Resident #8. LPN #6 stated, "None, they were all taken away." LPN #6 was asked specifically about the order for the low bed. LPN #6 stated, "It was discontinued, fairly recently." LPN #6 was asked to review Resident #8's clinical record and demonstrate where the low bed was discontinued. LPN #6 stated, "We do not have an order to discontinue the low bed. We have not been maintaining a low bed. He is doing so well." LPN #6 was asked the purpose of the care plan. LPN #6 stated the care plan was to direct the care specific to a resident. LPN #6 was shown Resident #8's care plan for safety and the documentation for, "Bed in low position." LPN #6 stated, "(Name of Resident #8's) care plan does not reflect the care we are currently providing. When asked if the care should follow the care plan, LPN #6 stated, "Yes it should. We haven't been doing it. The low bed should still be in place and he has not been on a low bed."

On 6/21/17 at 11:45 a.m. a meeting was conducted with ASM (administrative staff member) #1, the administrator and ASM #2, the director of clinical services. ASM #1 and ASM #2 were made aware that the nursing staff had not been following the written plan of care for Resident #8. His bed was not being kept in the low position when he was in the bed. A policy was requested at this time regarding following the care plan.

The facility document titled, "Plans of Care" revealed, in part, the following documentation;

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F 323	Continued From page 54 "Policy: An interdisciplinary plan of care will be established for each resident and updated in accordance with state and federal regulatory requirements and on an as needed bases. Procedure: Direct care staff should be aware, understand and follow their Resident's Plan of Care." No further information was provided prior to the end of the survey process.	F 323		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 514		

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and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for two of 19 residents in the survey sample, Resident # 1 and Resident #5.

1. The facility staff failed to file the results of a Modified Barium Swallow study in Resident # 1's clinical record.

2. The facility staff failed to document Resident #5's daily fluid intake as ordered by the physician.

The findings include:

1. The facility staff failed to file the results of a Modified Barium Swallow study in Resident # 1's clinical record.

Resident # 1 was admitted to the facility on 10/10/16 with diagnoses that included but were not limited to: anemia, hypertension (high blood pressure), Parkinson's disease (1), diabetes (2), arthritis, hypothyroidism (3), and depression (4). Resident # 1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/27/17, coded

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1. The MBS results were filed on the resident #1's medical record on 6/20/17. The fluid intake documentation prior to 6/21/17 cannot be corrected for resident #5.

2.A 100% quality review was completed on 7/11/17 to ensure the results of MBS studies were available on the medical record and fluid intakes were documented per physician orders . There were no additional findings.

3. The policies entitled "Clinical/Medical Records" and "Fluid restriction" was reviewed and no changes are warranted at this time. Nursing staff were re-educated on these policies on or before 7/14/17.

4. The DCS/designee will perform a quality review of medical records of residents with new orders for MBS and fluid intake monitoring once per week. Any negative findings will be corrected immediately and will be reported to the facilities QAPI meeting monthly for 3 months at which time if no further incident is noted it will be monitored intermittently thereafter.

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the resident as scoring a 12 out of 15 on the brief interview for mental status, indicting the resident was cognitively intact.

During a review of Resident # 1's clinical record a physician order signed and dated on 3/29/17 documented: "Modified Barium Swallow".

During a further review of the clinical record the documented results of the Modified Barium Swallow being completed could not be located.

During an interview on 6/20/17 at 2:20 p.m. with ASM (administrative staff member) # 2, DCS (director of clinical services), a request was made for the missing report.

On 6/20/17 at 3:35 p.m. the ASM # 2 presented a copy of the Modified Barium Swallow that was completed on 4/4/17. When asked where it was located ASM # 2 stated that the report was not in the building.

During an interview on 6/20/17 at approximately 6:00 p.m. with ASM # 1, the administrator, and ASM # 2, this concern was reviewed and a copy of the facility policy was requested.

Review of the facility policy revealed the following documentation: "Clinical/Medical Records" "Policy: ...Clinical Records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care. The clinical record shall contain-information to identify the resident clearly; a record of the resident's assessments; the plan of care and services; the results of pre-admission screening; and progress notes which indicate change toward achieving the

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care plan objectives. In addition, the resident's clinical record shall be readily accessible and systematically organized to facilitate retrieving and compiling information ...The purpose of the clinical record is to document the course of the resident's plan of care and to provide a medium of communication among health care professionals involved in this care."

No further information was provided prior to exit.

References:

(1) Parkinson's Disease -- Parkinson's is a disease of the nervous system that mostly affects older people. It typically begins after the age of 50. The disease can be very hard to live with because it severely restricts mobility and as a result makes daily activities increasingly difficult. This information was obtained from the following website; https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0024544/

(2) Diabetes is a disease in which your blood glucose, or blood sugar, levels are too high. Glucose comes from the foods you eat. This information was obtained from the following website; https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=Diabetes&commit=Search

(3) Hypothyroidism -- The thyroid gland performs a vital function: It produces the hormones that regulate the body's metabolism and keep them in balance. Thyroid hormones direct many of the body's processes. An underactive thyroid does not produce enough hormones. This condition is

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also referred to as hypothyroidism. This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0022776/

(4) Depression (major depressive disorder or clinical depression) is a common but serious mood disorder. It causes severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. https://www.nimh.nih.gov/health/topics/depression/index.shtml

2. The facility staff failed to document Resident #5's daily fluid intake as ordered by the physician.

Resident #5 was admitted to the facility on 3/27/17 with diagnoses that included, but were not limited to; heart failure, high blood pressure, dementia, asthma and atrial fibrillation (an irregular heart rhythm).

Resident #5's most recent comprehensive MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 4/3/17. Resident #5 was coded as scoring three out of a possible 15 indicating that she is cognitively severely impaired with daily decision making. Resident #5 was also coded in Section N, Medications, as receiving a diuretic (a medication that increases the production of urine) each day during the seven day look back period.

A review of Resident #5's physician orders revealed, in part, the following order: "Date: 3/29/17. Rec (recommendation): 2.0 L (liters) fluid restriction breakdown = 1080 cc (cubic centimeters) via dietary. 920 cc via nursing."

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Signed and dated by ASM (administrative staff member) #3, the nurse practitioner, on 4/3/17."

A review of Resident #5's MAR (medication administration record) dated June 2017 revealed, in part, the following order: "2.0 Liter fluid restriction. 1080 (cc) via dietary - 920 (cc) via nursing." For each date and each shift beginning June 1 - June 20 nursing initials were documented indicating that the fluid restriction was administered. However there were no documented amounts for Resident #5's fluid intake on any date.

A review of Resident #5's comprehensive care plan dated 3/27/17 revealed, in part, the following documentation: "Focus: Potential fluid imbalance r/t (related to) h/o (history of) dehydration on admission to hospital, use of diuretic, 2000 l (liter) fluid restrictions and dx (diagnosis) of CHF (congestive heart failure). Interventions: Fluid restriction as ordered."

Further review of Resident #5's clinical record did not reveal any documentation of the amounts of fluid Resident #5 consumed on each shift.

On 6/20/17 at 4:10 p.m. ASM (administrative staff member) #2, the director of clinical services, approached this writer and stated, "The staff have not been documenting the fluid intake amount for (name of Resident #5). They (the staff) signed off on the MAR acknowledging there was a fluid restriction, but they did not document how much fluid she (Resident #5) had consumed each day." A policy was requested at this time on fluid restriction.

On 6/21/17 at 11:45 a.m. a meeting was

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F 514	Continued From page 60 conducted with ASM #1, the administrator and ASM #2, the director of clinical services. ASM #1 and ASM #2 were made aware that the facility staff was not documenting the amount of fluid intake for Resident #5 from shift to shift. ASM #2 was asked if the amount of fluid intake should be documented on the MAR, ASM #2 stated that it should. On 6/21/17 at 12:22 p.m. an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked to describe the process for monitoring a fluid restriction for a resident. LPN #4 stated that the fluid restriction would be entered into the MAR for the nursing staff to check off and dietary would be informed. When asked if she wrote the amount of fluids the resident takes in during the shift LPN #4 stated, "No, we just know, we ask the aides and they know not to leave fluids in the room but that is just our shift, we don't know from shift to shift how much fluid intake there has been." LPN #4 was asked to review Resident #5's MAR. LPN #4 was asked if she could track how much fluid Resident #5 had received since midnight. LPN #4 stated, "I can only say what she has had for me, I can't say what she has had prior to my shift and I won't be able to say what the intake will be next shift." LPN #4 was asked to state the purpose of the entry in the MAR, LPN #4 stated, "Right now we just acknowledge that she (Resident #5) is on a fluid restriction." A review of the facility policy titled "Fluid Restrictions" revealed, in part, the following documentation; "Policy: This facility is responsible for insuring that all residents receive adequate intake within the limitations determined by the attending physician. Procedure: The	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495315	A. BUILDING _____ B. WING _____	06/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF WOODSTOCK	803 SOUTH MAIN ST WOODSTOCK, VA 22664

(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 514	Continued From page 61 resident will have fluid restrictions calculated so that he/she can have intake on each shift based on resident preferences. In calculating intake per shift, keep in mind fluid required for resident to take medications and desired at mealtimes." No further information was provided prior to the end of the survey process.	F 514		

1/30/17