STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495279	A. BUILDING _____ B. WING _____	C 08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CULPEPER HEALTH & REHABILITATION CENTER	602 MADISON ROAD CULPEPER, VA 22701

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/8/17 through 8/9/17. Corrections are 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 180 bed facility was 147 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents #1 through #21) and three closed record reviews (# 22 through #24).	F 000		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or	F 225		8/29/17

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

Electronically Signed | 08/18/2017

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licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate

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F 225	Continued From page 2 corrective action must be taken. 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 report an allegation of sexual abuse to the administrator and failed to complete an investigation for one of 24 residents in the survey sample, Resident #13. A nurse's note documented that Resident #13 had his hand on a female resident's breast in the dining room on 3/5/17. The allegation was not reported to the administrator, and no investigation was completed. The findings include: Resident #13 was admitted to the facility on 9/11/14 with diagnoses that included but were not limited to: benign neoplasm (non-cancerous tumors) of the brain and bladder, seizures, diabetes, intellectual disability, dementia, schizophrenia, high blood pressure and paraphilia * Paraphilia is a recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving i) non-human objects, ii) the suffering or humiliation of oneself or one's partner, or iii) children or other non-consenting persons that occur over a period of at least 6 months. (1) The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/23/17 coded the resident as scoring a nine on the BIMS (brief interview for mental status score), indicating he	F 225	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F225 1. Documentation review was completed on Resident #13 and FRI submitted to Virginia Department of Health and the Department of Health Professions on 08/10/2017. MD/RP were notified on the same date above of the incident 2. Documentation review of current residents on 08/16/2017 for a progress note review to ensure no other abuse related incidents had been documented without proper communication. Any such incident found will be immediately addressed accordingly 3. Re-education with the facility staff to include: a. The MFA policy/procedure and State/Federal regulation on abuse and reporting guidelines b. Appropriate documentation and follow-up protocols for reportable	

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F 225	Continued From page 3 was moderately impaired to make cognitive daily decisions. The resident was coded as being independent or requiring supervision for most of his activities of daily living. Resident #13 was coded as requiring more assistance for personal hygiene and bathing. Resident #13 was coded as ambulating on and off the unit independently with the use of a cane. The clinical record was reviewed on 8/8/17. The nurse's note dated, 3/5/17 at 2:41 p.m. documented, "Behavior Note: Resident observed by staff touching another resident inappropriately in the dining room after lunch. Female resident observed allowing resident to touch her, not pushing his hands away. Both resident confronted by staff. Female resident states she did not consent to him touching her. Non-pharmacological interventions: Resident was educated on his behavior and sent to his room. Effect: Resident voiced understanding, informed female resident's nurse of incident. PRN (as needed) medications: n/a (not applicable). Outcome: will monitor for further behaviors and sexual inappropriateness." A request was made on 8/9/17 at 9:16 a.m. for the incident report that corresponded to the above note and date. The care plan dated, 8/8/17 documented in part, "Resident has the potential to display the following behaviors: Sexually inappropriate at times, aggression, refusing care." The "Interventions" documented, "Offer snack/drink. 1:1 (one to one) redirection, diversional activity (Resident enjoys listening to country music, watching action movies." These interventions were added to the care plan on 8/8/17.	F 225	incidents 4. The administrator/DON/designee will complete 10% audit of current residents documentation records weekly X 2 weeks, monthly X 2 months, and quarterly X 1 to ensure that appropriate protocols are followed on all reportable incidents. Any deviation noted will be rectified accordingly. The findings will also be forwarded to the QA committee for further review and recommendation.	

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F 225	Continued From page 4	F 225		

On 8/9/17 at 11:22 a.m. ASM (administrative staff member) #1, the administrator, informed this surveyor that the incident above was not brought to his attention. The DON (director of nursing) at that time was no longer employed here and the nurse who documented the note was no longer employed at the facility. The facility was attempting to contact her (the nurse) to find out who the female resident was and to obtain statements regarding this but the attempts were unsuccessful. The female resident was unidentifiable while the survey team was in the building.

An interview was conducted with CNA (certified nursing assistant) #1 on 8/9/17 at 11:22 a.m., regarding inappropriate touching between residents, CNA #1 stated, "You separate the resident, go to the nurse and the nurse goes to the unit manager or supervisor and they report it to the DON, social worker or administrator." When asked what she would do if she knew the nurse didn't report it or do anything about it, CNA #1 stated, "I'd go to the social worker to see if it was reported and if not report it."

An interview was conducted with RN (registered nurse) #2 on 8/9/17 at 11:24 a.m., regarding the process followed for inappropriate resident to resident touching. RN #2, stated, "Calmly as possible I would remove the residents from each other. I would inform the supervisor. Assess both residents. Notify the RP (responsible party) and the doctor or nurse practitioner." When asked how she would know it was reported to the appropriate people, RN #2 stated, "I'd check with my supervisor or higher ups." When asked if she had had any problems with things not being

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reported, RN #2 stated, "No, Ma'am."

An interview was conducted with LPN (licensed practical nurse) #2, the interim unit manager, on 8/9/17 regarding the process followed for inappropriate resident to resident touching. LPN #2 stated, "First make sure the residents were separated. Then I would obtain full witness statements from any witness or staff members. I would take statements from both residents. Notify the doctor and RP. Fill in an incident report. Report it to the supervisor. If it was suspected abuse, which that would most likely be, I'd notify the DON (director of nursing), ADON (assistant director of nursing), unit manager and supervisor." When asked what happens if staff does not report an incident, LPN #2 stated, "That's not good."

An interview was conducted with ASM #1, the administrator, on 8/9/17 at 11:40 a.m. When about the process followed at the facility for inappropriate resident to resident touching, ASM #1 stated, "First, separate the residents. Assess each resident for injury. Notify the supervisor, doctor and RP. Then notify the abuse coordinator." When asked who the abuse coordinator is, ASM #1 stated, "he was."

The facility policy, "Abuse/Investigative Reporting" documented in part, "Procedure: 1. Any staff observing or suspecting abuse, neglect or mistreatment will remove the patient from danger immediately and report to their immediate supervisor. 2. A licensed nurse will assure patient safety by removing the accused employee, visitor or other patient from the area. 3. A licensed nurse will notify the Administrator and/or the Director of Nursing immediately. 4. A

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licensed nurse will closely monitor and document thoroughly the behavior and condition of the patient involved to evaluate any injury. 5. For all patients involved in the incident, a licensed nurse must notify the following: a. attending physician, b. responsible party. 6. The administrator or Director of Nursing will notify their Nurse Consultant or the Vice President of Clinical Services of the incident and will provide an update to the status of the Center's immediate investigation and the plans for initiation the initial notification to the State Survey Agency and other appropriate agencies. 7. An incident report must be completed by a licensed nurse...9. The Administrator or his/her designee must initiate an investigation within 2 or 24 hours of their knowledge of the alleged incident. This investigation includes interviewing all staff involved (directly or indirectly), any family involved, all patients involved and any visitor involved. 10. The administrator and/or his designee will immediately notify (within 2 or 24 hours of knowledge of the allegation) Adult Protective Services Agency, the local ombudsman, and the appropriate local law enforcement authorities."

ASM #1, ASM #2, the interim DON, ASM #3, the ADON and ASM #4, the nurse consultant, were made aware of the above concern on 8/9/17 at 12:47 p.m.

No further information was obtained prior to exit.

(1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3769077/

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F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that	F 226	F226 1. Documentation review was completed	8/29/17

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F 226	Continued From page 8 the facility staff failed to follow their policies on reporting and investigating an allegation of sexual abuse for one of 24 residents in the survey sample, Resident #13. A nurse's note documented that Resident #13 had his hand on a female resident's breast in the dining room on 3/5/17. No investigation was completed as it was not reported to the administrator. The findings include: Resident #13 was admitted to the facility on 9/11/14 with diagnoses that included but were not limited to: benign neoplasm (non-cancerous tumors) of the brain and bladder, seizures, diabetes, intellectual disability, dementia, schizophrenia, high blood pressure and paraphilia * Paraphilia is a recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving i) non-human objects, ii) the suffering or humiliation of oneself or one's partner, or iii) children or other non-consenting persons that occur over a period of at least 6 months. (1) The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/23/17 coded the resident as scoring a nine on the BIMS (brief interview for mental status score), indicating he was moderately impaired to make cognitive daily decisions. The resident was coded as being independent or requiring supervision for most of his activities of daily living. The resident was coded as requiring more assistance for personal	F 226	on Resident #13 and FRI submitted to Virginia Department of Health and the Department of Health Professions on 08/10/2017. MD/RP were notified on the same date above of the incident 2. Documentation review of current residents completed on 08/16/2017 to ensure no progress note has unreported reportable incidents. All abnormal findings will be followed upon accordingly. 3. Re-education with the facility staff to include: a. The MFA policy/procedure and State/Federal regulation on abuse and reporting guidelines b. Appropriate documentation and follow-up protocols for reportable incidents 4. The administrator/DON/designee will complete 10% audit of current residents documentation records weekly X 2 weeks, monthly X 2 months, and quarterly X 1 to ensure that appropriate protocols are followed on all reportable incidents. Any deviation noted will be rectified accordingly. The findings will also be forwarded to the QA committee for further review and recommendation.	

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hygiene and bathing. Resident #13 was coded as ambulating on and off the unit independently with the use of a cane.

The clinical record was reviewed on 8/8/17. The nurse's note dated, 3/5/17 at 2:41 p.m. documented, "Behavior Note: Resident observed by staff touching another resident inappropriately in the dining room after lunch. Female resident observed allowing resident to touch her, not pushing his hands away. Both resident confronted by staff. Female resident states she did not consent to him touching her. Non-pharmacological interventions: Resident was educated on his behavior and sent to his room. Effect: Resident voiced understanding, informed female resident's nurse of incident. PRN (as needed) medications: n/a (not applicable). Outcome: will monitor for further behaviors and sexual inappropriateness."

A request was made on 8/9/17 at 9:16 a.m. for the incident report that corresponded to the above note and date.

The care plan dated, 8/8/17 documented in part, "Resident has the potential to display the following behaviors: Sexually inappropriate at times, aggression, refusing care." The "Interventions" documented, "Offer snack/drink. 1:1 (one to one) redirection, diversional activity (Resident enjoys listening to country music, watching action movies." These interventions were added to the care plan on 8/8/17.

On 8/9/17 at 11:22 a.m. ASM (administrative staff member) #1, the administrator, informed this surveyor that the incident above was not brought to his attention. The DON (director of nursing) at

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that time was no longer employed here and the nurse who documented the note was no longer employed at the facility. The facility was attempting to contact her (the nurse) to find out who the female resident was and to obtain statements regarding this but the attempts were unsuccessful. The female resident was unidentifiable while the survey team was in the building.

An interview was conducted with CNA (certified nursing assistant) #1 on 8/9/17 at 11:22 a.m., regarding inappropriate touching between residents, CNA #1 stated, "You separate the resident, go to the nurse and the nurse goes to the unit manager or supervisor and they report it to the DON, social worker or administrator." When asked what she would do if she knew the nurse didn't report it or do anything about it, CNA #1 stated, "I'd go to the social worker to see if it was reported and if not report it."

An interview was conducted with RN (registered nurse) #2 on 8/9/17 at 11:24 a.m., regarding the process followed for inappropriate resident to resident touching. RN #2, stated, "Calmly as possible I would remove the residents from each other. I would inform the supervisor. Assess both residents. Notify the RP (responsible party) and the doctor or nurse practitioner." When asked how she would know it was reported to the appropriate people, RN #2 stated, "I'd check with my supervisor or higher ups." When asked if she had had any problems with things not being reported, RN #2 stated, "No, Ma'am."

An interview was conducted with LPN (licensed practical nurse) #2, the interim unit manager, on 8/9/17 regarding the process followed for

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inappropriate resident to resident touching. LPN #2 stated, "First make sure the residents were separated. Then I would obtain full witness statements from any witness or staff members. I would take statements from both residents. Notify the doctor and RP. Fill in an incident report. Report it to the supervisor. If it was suspected abuse, which that would most likely be, I'd notify the DON (director of nursing), ADON (assistant director of nursing), unit manager and supervisor." When asked what happens if staff does not report an incident, LPN #2 stated, "That's not good."

An interview was conducted with ASM #1, the administrator, on 8/9/17 at 11:40 a.m. When about the process followed at the facility for inappropriate resident to resident touching, ASM #1 stated, "First, separate the residents. Assess each resident for injury. Notify the supervisor, doctor and RP. Then notify the abuse coordinator." When asked who the abuse coordinator is, ASM #1 stated, "he was."

The facility policy, "Abuse/Investigative Reporting" documented in part, "Procedure: 1. Any staff observing or suspecting abuse, neglect or mistreatment will remove the patient from danger immediately and report to their immediate supervisor. 2. A licensed nurse will assure patient safety by removing the accused employee, visitor or other patient from the area. 3. A licensed nurse will notify the Administrator and/or the Director of Nursing immediately. 4. A licensed nurse will closely monitor and document thoroughly the behavior and condition of the patient involved to evaluate any injury. 5. For all patients involved in the incident, a licensed nurse must notify the following: a. attending physician,

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F 226	Continued From page 12 b. responsible party. 6. The administrator or Director of Nursing will notify their Nurse Consultant or the Vice President of Clinical Services of the incident and will provide an update to the status of the Center's immediate investigation and the plans for initiation the initial notification to the State Survey Agency and other appropriate agencies. 7. An incident report must be completed by a licensed nurse...9. The Administrator or his/her designee must initiate an investigation within 2 or 24 hours of their knowledge of the alleged incident. This investigation includes interviewing all staff involved (directly or indirectly), any family involved, all patients involved and any visitor involved. 10. The administrator and/or his designee will immediately notify (within 2 or 24 hours of knowledge of the allegation) Adult Protective Services Agency, the local ombudsman, and the appropriate local law enforcement authorities." ASM #1, ASM #2, the interim DON, ASM #3, the ADON and ASM #4, the nurse consultant, were made aware of the above concern on 8/9/17 at 12:47 p.m. No further information was obtained prior to exit. (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3769077/	F 226		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10	F 280		8/29/17

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(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

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

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

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

483.21

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F 280	Continued From page 14 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 280	F280	

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F 280	Continued From page 15 document review and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for three of 24 residents in the survey sample, Resident #5, Resident #21 and Resident #11. 1. The facility staff failed to review and revise the comprehensive care plan following Resident #5's falls on 3/4/17 and 5/1/17. 2. The facility staff failed to review and revise the comprehensive care plan for Resident #21 following two falls that occurred in the facility on 11/4/17 and 12/28/16, and for the diagnosis and treatment of a urinary tract infection that occurred on 2/25/17. 3. The facility staff failed to review and revise the comprehensive care plan for Resident #11 following a fall that occurred in the facility on 6/2/17. The findings include: 1. Resident #5 was admitted to the facility on 1/6/17 with diagnoses that included but were not limited to: diabetes, high blood pressure, irregular heart beat and peripheral vascular disease (1). The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/13/17 coded the resident as having scored 15 out of 15 on the BIMS (brief interview for mental status) assessment indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring some assistance from staff for activities of daily living but could feed self independently.	F 280	1. Resident #5 falls care plan focus reviewed and updated on 8/18/2017 to reflect falls on 3/4/17 and 5/1/2017. Resident #21 care plan focuses on falls/UTI reviewed and updated on 8/18/2017 to reflected falls on 11/4/16 and 12/28/2016, and UTI infection on 2/25/2017 accordingly. Resident #11 fall care plan focus reviewed and revised to reflect a fall that occurred on 6/2/2017. 2. Care plans audit for current residents that have had falls in the last 30 days from 7/16/2017 will be completed to ensure that they were reviewed and revised with every fall that occurred. Any anomaly noted will be rectified accordingly. 3. Re-education with the facility nursing staff to include: a. Process of initiating, revising, updating, and resolving resident□s individualized careplans. b. MFA policy and procedure on resident assessment and careplanning. c. MFA P&P on fall management 4. The DON/designee will audit 10% of the care plans for current residents with a fall weekly X 2 weeks, monthly X 2 months, and quarterly X 1 to ensure accurate review and revision of fall care plan focus was completed for every fall that occurred. Any deviation noted will be forwarded to the QA committee for further review and resolution.	

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Review of the nurse's notes dated 3/4/17 documented the resident had fallen when attempting to get into bed. There was no documentation that the comprehensive care plan had been reviewed or revised at that time. Review of the nurse's notes dated 5/1/17 documented that the resident had fallen in her room. There was no documentation that the comprehensive care plan had been reviewed or revised at that time.

Review of the comprehensive care plan created on 1/6/17 and revised on 8/8/17 did not evidence documentation that the care plan had been reviewed or revised following the 3/4/17 and 5/1/17 falls.

An interview was conducted on 8/9/17 at 9:30 a.m. with LPN (licensed practical nurse) #2, the interim unit manager. When asked who reviewed and revised care plans, LPN #2 stated, "Nurses and unit manager. Anyone who has access to the care plan." LPN #2 was asked when a residents care plan would be reviewed and revised. LPN #2 stated, "Whenever there is a change in condition, any new orders, any change in treatment. Falls are on the care plan too." When asked if new interventions were documented on the care plan following a fall, LPN #2 stated, "Yup." When asked why care plans were reviewed and revised, LPN #2 stated, "So all the nurses and CNAs (certified nursing assistants) can see it and are notified (of a change in the resident's plan of care)." When asked to review Resident #5's care plan for the falls on 3/4/17 and 5/1/17, LPN #2 stated, "Well that one doesn't have an intervention."

An interview was conducted on 8/9/17 at 11:40

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a.m. with LPN #4. When asked who used the residents care plans, LPN #4 stated, "The whole team." When asked when a resident's care plan was updated, LPN #4 stated, "When there's a change in condition, and it is updated when there are new orders." When asked why the care plan would be updated, LPN #4 stated, "Because the plan of care changes."

On 8/9/17 at 12:50 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, ASM #3, the assistant director of nursing and ASM #4, the nurse consultant were made aware of the findings.

Review of the facility's policy titled, "Care Planning" documented in part, "POLICY: A licensed nurse coordinates with the interdisciplinary team the development and implementation of an individualized care plan for each patient. PROCEDURE: 4. Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur..."

No further information was provided prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and

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with new orders..." (1)

(1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."

1. Peripheral vascular disease -- Peripheral artery disease (P.A.D.) is a disease in which plaque builds up in the arteries that carry blood to your head, organs, and limbs. Plaque is made up of fat, cholesterol, calcium, fibrous tissue, and other substances in the blood. This information was obtained from: https://www.nhlbi.nih.gov/health/health-topics/topics/pad/

2. The facility staff failed to review and revise the comprehensive care plan for Resident #21 following two falls that occurred in the facility on 11/4/17 and 12/28/16, and for the diagnosis and

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treatment for a urinary tract infection that occurred on 2/25/17.

Resident #21 was admitted to the facility on 7/1/15 with a readmission date of 8/7/17 with diagnoses that include, but are not limited to: chronic obstructive pulmonary disease, rheumatoid arthritis, difficulty swallowing, depression, diabetes, anxiety and enlarged prostate.

Resident #21's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/18/17, coded Resident #21 as scoring 13 out of a possible 15 on the BIMS (brief interview for mental status), indicating that Resident #21 is cognitively intact with daily decision making.

A review of Resident #21's clinical record revealed, in part, that Resident #21 had fallen on 11/4/16 and 12/28/16.

Further review of Resident #21's clinical record revealed, Resident #21 had been diagnosed and treated for a urinary tract infection on 2/25/17.

A review of Resident #21's comprehensive care plan dated 7/2/2015 did not reveal any documentation of a review of the care plan following either fall above or for the urinary tract infection.

On 8/9/17 at 9:45 a.m. an interview was conducted with LPN (licensed practical nurse) #2, the interim unit manager on unit 2. LPN #2 was asked who was responsible for reviewing and revising the comprehensive care plans. LPN #2 stated that all nurses and any staff members who

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had access to the care plans could review them and make revisions. LPN #2 was asked under what circumstances a comprehensive care plan would be reviewed and revised, LPN #2 stated changes in treatments or therapies would require the care plan to be reviewed and revised. When asked specifically about infections or falls, LPN #2 stated they (infections and falls) would be reasons to review a care plan.

On 8/9/17 at approximately 2:30 p.m. ASM (administrative staff member) #3, the assistant director of nursing, was asked if she was able to provide evidence that Resident #21's care plan had been reviewed and/or revised following the falls on 11/4/16 and 12/28/16 and the urinary tract infection on 2/25/17. ASM #3 stated that she would look at the documentation in the clinical record and bring any evidence that she had.

On 8/9/17 at 3:43 p.m. ASM #4, the corporate nurse consultant, approached this surveyor to review the comprehensive care plan for Resident #21 in regards to the two falls on 11/4/16 and 12/28/16 and the urinary tract infection on 2/25/17. ASM #4 agreed there was no documentation that evidenced the facility conducting a review of Resident #21's comprehensive care plan following the aforementioned events. A policy was requested at this time in regards to reviewing and revising comprehensive care plans.

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

3. The facility staff failed to review and revise the comprehensive care plan for Resident #11

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following a fall that occurred in the facility on 6/2/17.

Resident #11 was admitted to the facility on 2/1/17 with diagnoses that include, but are not limited to: stroke, neuropathy (diminished nerve conduction in extremities), chronic kidney disease, cardiovascular disease, high blood pressure, diabetes and high levels of lipids in the blood stream.

Resident #11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/26/17, coded Resident #11 as scoring 13 out of a possible 15 on the BIMS (brief interview for mental status), indicating that Resident #11 is cognitively intact with daily decision making.

A review of Resident #11's clinical record revealed, in part, that Resident #11 had fallen on 6/2/17.

A review of Resident #11's comprehensive care plan dated 2/1/17 did not reveal any documentation of a review of the care plan following the fall on 6/2/17.

On 8/9/17 at 9:45 a.m. an interview was conducted with LPN (licensed practical nurse) #2, the interim unit manager on unit 2. LPN #2 was asked who was responsible for reviewing and revising the comprehensive care plans. LPN #2 stated that all nurses and any staff members who had access to the care plans could review them and make revisions. LPN #2 was asked under what circumstances a comprehensive care plan would be reviewed and revised, LPN #2 stated changes in treatments or therapies would require

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F 280	Continued From page 22 the care plan to be reviewed and revised. When asked specifically about infections or falls, LPN #2 stated they (infections and falls) would be reasons to review a care plan. LPN #2 was asked to review Resident #11's comprehensive care plan, and asked if there was evidence that his care plan was reviewed following his fall on 6/2/17. LPN #2 stated it (Resident #11's care plan) was not reviewed or revised. LPN #2 further stated the care plans should be at the very least reviewed following every incident, and when the incident is a fall there should be a new intervention for every fall. When asked if that was done for Resident #11 LPN #2 stated it was not. On 8/9/17 at 12:50 p.m. a meeting was conducted with ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, ASM #3, the assistant director of nursing, and ASM #4, the corporate nurse consultant. ASM #1, ASM #2, ASM #3 and ASM #4 were made aware of the above concern. No further information was provided prior to the end of the survey process.	F 280		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281		8/29/17

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F 281	Continued From page 23 by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of 24 residents in the survey sample, Resident #5. The facility staff failed to clarify the physician's order for Resident #5's heels to be floated at all times written on 3/10/17. The findings include: Resident #5 was admitted to the facility on 1/6/17 with diagnoses that included but were not limited to: diabetes, high blood pressure, irregular heart beat and peripheral vascular disease (1). The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/13/17 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) assessment indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring some assistance from staff for activities of daily living but could feed self independently. The resident was coded as having a pressure ulcer on the left heel. An observation was made on 8/8/17 at 11:10 a.m. Resident #5 was sitting up in a chair next to the bed. Her feet were resting on the floor. An observation was made on 8/8/17 at 1:55 p.m. Resident #5 was sitting up in a chair next to the bed. Her feet were resting on the floor.	F 281	F281 1. Resident # 5 physician□s order on Float heels at all times was reviewed and a clarification order received to change the order to float heels when in bed on 8/18/2017. 2. Current patients with physician□s order to float heels will be reviewed to ascertain clarity and appropriateness. All unclear floating heels orders found will be clarified with the physician accordingly. 3. Re-education of facility nursing staff to include: a. Description of floating heels order appropriateness/clarity and process for receiving clarification orders b. Policy and procedure on physician order and clarification 4. The DON/designee will audit weekly X2 weeks, monthly X2 months, and quarterly X 1 all current residents with physician orders for floating heels to ensure clarity and appropriateness. Any deviation noted will be rectified accordingly. Any finding will also be forwarded to the QA committee for further review and recommendation.	

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Review of the physician's orders dated 6/12/17 documented, "Float heels at all times > (to decrease) danger of limb loss."

Further review of the physician's orders dated August 2017 documented, "Float heels every shift for left heel wound. Order Date. 03/10/2017."

Review of the August 2017 treatment administration record documented, "Float heels every shift for left heel wound. Order Date. 03/10/2017." It was documented that the heels were floated every shift for each day from 8/1/17 to 8/8/17.

Review of the care plan created on 1/6/17 and revised on 7/18/17 documented, "Float heels."

An interview was conducted on 8/8/17 at 1:55 p.m. with Resident #5. When asked if staff assisted her with activities, Resident #5 stated, "Yes they do. When I get into bed they put pillows under my legs so I can float my heels." When asked if she floated her heels when she sat up in the chair, Resident #5 stated she did not.

An interview was conducted on 8/9/17 at 9:45 a.m. with LPN (licensed practical nurse) #2, the interim unit manager. When asked to review the physician's order, LPN #2 stated, "Float the heels whenever in bed or even when she's up in the wheelchair. They don't want her legs to be hanging." When asked why the physician didn't want the resident's legs to be hanging, LPN #2 stated, "For possible limb loss. She has PVD (peripheral vascular disease (1)) and she already has had an amputation on one of her legs."

An observation was made on 8/9/17 at 9:50 a.m.

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of Resident #5 with LPN #2. The resident was sitting in a chair next to the bed with her legs dangling down and her feet resting on the floor. LPN #2 stated, "I see, she needs to have her legs elevated."

An interview was conducted on 8/9/17 at 11:00 a.m. with LPN #3, the resident's nurse. When asked to review the physician's order to float the heel at all times, LPN #3 stated, "I'm not 100 percent sure about that but I will check." LPN #3 returned shortly and stated, "Usually we only float heels when they are in the bed so we are going to clarify that order because she can move her limbs completely."

An interview was conducted on 8/9/17 at 2:00 p.m. with LPN #1. When asked to review the physician's order to float Resident #5's heels at all times, LPN #1 stated, "I would contact the doctor who wrote those orders because that's not a clear order. You always clarify (orders) with the doctor. That's nursing 101."

On 8/9/17 at 3:25 p.m. ASM (administrative staff member) #2, the interim director of nursing and ASM #3, the assistant director of nursing were made aware of the findings.

On 8/9/17 at 4:25 ASM #4 was asked what professional standard the facility used, ASM #4 stated, "Potter and Perry."

Review of the facility's policy titled, "Physician's Orders" did not evidence documentation regarding clarifying orders.

No further information was provided prior to exit.

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F 281	Continued From page 26 According to Potter and Perry's, Fundamentals of Nursing, 7th edition, page 268 documents the following statements: "Clarifying an order is competent nursing practice, and it protects the client and members of the health care team. When you carry out an incorrect or inappropriate intervention, it is as much your error as the person who wrote or transcribed the original order." 1. Peripheral vascular disease -- Peripheral artery disease (P.A.D.) is a disease in which plaque builds up in the arteries that carry blood to your head, organs, and limbs. Plaque is made up of fat, cholesterol, calcium, fibrous tissue, and other substances in the blood. This information was obtained from: https://www.nhlbi.nih.gov/health/health-topics/topics/pad/	F 281		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (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, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow the written plan of care for one of 24 residents in the survey sample, Resident #3.	F 282	F282 1. Resident #3 was repositioned as for non-pharmacological pain management intervention on 8/9/2017. LPN #4 re-educated on non-pharmacological	8/29/17

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F 282	Continued From page 27 The facility staff failed to attempt non-pharmacological interventions for pain relief as documented in Resident #3's care plan. The findings include: Resident #3 was admitted to the facility on 8/5/17 with diagnoses that included but were not limited to: right mastectomy, anemia, high blood pressure and kidney failure. The most recent MDS (minimum data set), an entry assessment, with an ARD (assessment reference date) of 8/5/17 was an abbreviated MDS and did not include information regarding the resident's cognitive status or activity level. Review of the admission assessment dated 8/5/17 documented that the resident was oriented to person, place, time and situation. The resident was documented as needing some assistance from staff for activities of daily living but was able to feed self independently. Review of Resident #3's care plan created on 8/20/14 and revised on 8/6/17 documented, "Focus. The resident has acute/chronic pain r/t R (right) radical mastectomy...Interventions. Encourage to try different pain relieving methods i.e. positioning, relaxation therapy, progressive relaxation, bathing, heat and cold application, muscle stimulation, ultrasound." Review of the physician's orders dated August 2017 documented, "HYDROmorphone HCL (hydrochloride) (an opioid analgesic made from MORPHINE and used mainly as an analgesic (1)) Tablet 2 MG (milligrams). Give 2 mg by mouth every 8 hours as needed for r/t (related to) pain	F 282	intervention for pain management prior to the administration of pain medication on 8/9/2017. 2. Care plans for all patients on pain medication reviewed to identify those with non-pharmacological intervention for pain. Result of the review used to provide in-service to all nurses on non-pharmacological intervention for pain management 3. Re-education with the facility nursing staff to include: a. Non-pharmacological pain management b. Policy procedure on pain management c. Protocol in the administration of pharmacological pain management 4. The DON/designee will audit 10% of pain management documentation for current residents on pain medication weekly x2 weeks, monthly x 2 months, and quarterly x1 to ensure non-pharmacological intervention as applicable are completed. Any deviation noted will be forwarded to the QA committee for further review and resolution.	

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related to ACQUIRED ABSENCE OF RIGHT BREAST AND NIPPLE. Order date. 08/07/2017."

Review of the August 2017 MAR (medication administration record) documented, "HYDROmorphone HCL (hydrochloride) Tablet 2 MG (milligrams). Give 2 mg by mouth every 8 hours as needed for r/t (related to) pain related to ACQUIRED ABSENCE OF RIGHT BREAST AND NIPPLE. Order date. 08/07/2017."

An observation of medication administration to Resident #3 was made on 8/8/17 at 8:55 a.m. with LPN (licensed practical nurse) #4. Resident #3 complained of pain in her back. LPN #4 gave the resident hydromorphone 2 milligrams at that time. LPN #4 did not attempt to reposition the patient or offer any other non-pharmacological interventions prior to administering the pain medication.

An interview was conducted on 8/9/17 at 11:40 a.m. with LPN #4. When asked about the process staff followed when a resident complained of pain, LPN #4 stated, "I found out yesterday right after med (medication) pass that we're supposed to be offering non-pharmacological interventions before we give the med (medication)." When asked why residents had care plans, LPN #4 stated, "Because it's the plan of care." When asked if staff were expected to follow the care plan, LPN #4 stated they were.

An interview was conducted on 8/9/17 at 2:15 p.m. with LPN #3. When asked if staff were expected to follow the care plan, LPN #3 stated, "Yes." When asked if there was any time when staff would not follow the care plan, LPN #3 stated, "No, we never do not follow the care plan.

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It lists the patient needs and care and has interventions so we can implement them."

On 8/9/17 at 3:40 p.m. ASM (administrative staff member) #1, the interim director of nursing and ASM #2, the assistant director of nursing were made aware of the findings.

Review of the facility's policy titled, "Care Planning" documented in part, "POLICY: A licensed nurse coordinates with the interdisciplinary team the development and implementation of an individualized care plan for each patient. PROCEDURE: 8. A licensed nurse will review the care plan with the staff on his/her unit to ensure that care is rendered as outline on the care plan."

No further information was provided prior to exit.

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."

1. Hydromorphone -- Hydromorphone is an opioid

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F 282	Continued From page 30 analgesic made from MORPHINE and used mainly as an analgesic. It has a shorter duration of action than morphine. This information was obtained from: https://pubchem.ncbi.nlm.nih.gov/compound/hydromorphone#section=Top	F 282		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309		8/29/17

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F 309	Continued From page 31 (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and services to maintain the highest practicable level of well-being for two of 24 residents in the survey sample, Resident #3 and Resident #5. 1. a. The facility staff failed to offer non-pharmacological interventions prior to administering pain medication for Resident #3. b. The facility staff failed to follow the physician's order to administer hydromorphone for Resident #3's post mastectomy pain. The facility staff administered the hydromorphone on 8/8/17 for the resident's complaint of back pain and on 8/9/17 for the resident's complaint of knee pain. 2. The facility staff failed to follow the physician's order to obtain a blood glucose sample twice a day. The findings include: 1. a. Resident #3 was admitted to the facility on 8/5/17 with diagnoses that included but were not limited to: right mastectomy, anemia, high blood pressure and kidney failure. The most recent MDS (minimum data set), an	F 309	F309 1. Resident #3 hydromorphone medication order clarified with the MD and indication change from mastectomy to pain in general on 8/09/2017. Resident #5 blood glucose monitoring order was clarified with the physician for frequency of blood glucose sampling and order updated to include supplementary documentation for blood glucose reading on the MAR on 8/09/2017. 2. All residents with pain medication regimens and blood glucose orders were reviewed on 08/16/2017 for appropriateness and full implementation of physician orders. All anomalies noted rectified accordingly 3. Re-education with the facility nursing staff to include: a. Offering non-pharmacological interventions prior to administering medication b. Orders that require supplemental documentation c. Policy on physician order 4. The DON/designee will audit 10% of current diabetes residents on glucose monitoring weekly x2 weeks, monthly x2 months, and quarterly x1 to ensure appropriate indication for pain medication and full implementation of MD order for	

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entry assessment, with an ARD (assessment reference date) of 8/5/17 was an abbreviated MDS and did not include information regarding the resident's cognitive status or activity level. Review of the admission assessment dated 8/5/17 documented that the resident was oriented to person, place, time and situation. The resident was documented as needing some assistance from staff for activities of daily living but was able to feed self independently.

Review of Resident #3's care plan created on 8/20/14 and revised on 8/6/17 documented, "Focus. The resident has acute/chronic pain r/t R (right) radical mastectomy...Interventions. Encourage to try different pain relieving methods i.e. positioning, relaxation therapy, progressive relaxation, bathing, heat and cold application, muscle stimulation, ultrasound."

Review of the physician's orders dated August 2017 documented, "HYDROmorphone HCL (hydrochloride) (an opioid analgesic made from MORPHINE and used mainly as an analgesic (1)) Tablet 2 MG (milligrams). Give 2 mg by mouth every 8 hours as needed for r/t (related to) pain related to ACQUIRED ABSENCE OF RIGHT BREAST AND NIPPLE. Order date. 08/07/2017."

Review of the August 2017 MAR (medication administration record) documented, "HYDROmorphone HCL (hydrochloride) Tablet 2 MG (milligrams). Give 2 mg by mouth every 8 hours as needed for r/t (related to) pain related to ACQUIRED ABSENCE OF RIGHT BREAST AND NIPPLE. Order date. 08/07/2017."

An observation of medication administration to Resident #3 was made on 8/8/17 at 8:55 a.m.

blood glucose monitoring. Any deviation noted will be forwarded to the QA committee for further review and resolution.

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with LPN (licensed practical nurse) #4. Resident #3 complained of pain in her back. LPN #4 gave the resident hydromorphone 2 milligrams at that time. LPN #4 did not attempt to reposition the patient or offer any other non-pharmacological interventions prior to administering the pain medication.

An interview was conducted on 8/9/17 at 11:40 a.m. with LPN #4. When asked the process staff followed when a resident complained of pain, LPN #4 stated, "I found out yesterday right after med (medication) pass that we're supposed to be offering non-pharmacological interventions before we give the med."

An interview was conducted on 8/9/17 at 2:00 p.m. with LPN #5. When asked the process staff followed when a resident complained of pain, LPN #5 stated, "First we're going to do non-pharmacological interventions before giving a pain pill. We reposition them or try to distract them and then go back and re-evaluate the patient in ten to 15 minutes. If they are still in pain then I check to see what they have for pain and give them the pain med (medication)."

On 8/9/17 at 3:40 p.m. ASM (administrative staff member) #1, the interim director of nursing and ASM #2, the assistant director of nursing were made aware of the findings.

Review of the facility's policy titled, "Pain Management Assessments" documented, "5. Care plan specific interventions will be developed based on pain assessment and individual patient needs."

No further information was provided prior to exit.

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In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

1. Hydromorphone -- Hydromorphone is an opioid analgesic made from MORPHINE and used mainly as an analgesic. It has a shorter duration of action than morphine. This information was obtained from: https://pubchem.ncbi.nlm.nih.gov/compound/hydromorphone#section=Top

b. The facility staff failed to follow the physician's order to administer hydromorphone for Resident #3's post mastectomy pain.

Review of Resident #3's care plan created on 8/20/14 and revised on 8/6/17 documented, "Focus. The resident has acute/chronic pain r/t (related to) R (right) radical mastectomy...Interventions. Encourage to try different pain relieving methods i.e. positioning, relaxation therapy, progressive relaxation, bathing, heat and cold application, muscle stimulation, ultrasound, ..Administer analgesia per order."

Review of the physician's orders dated August 2017 documented, "HYDROmorphone HCL (hydrochloride) Tablet 2 MG (milligrams). Give 2 mg by mouth every 8 hours as needed for r/t (related to) pain related to ACQUIRED ABSENCE OF RIGHT BREAST AND NIPPLE. Order date.

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08/07/2017. Tylenol Tablet 325 MG (Acetaminophen) give 650 mg by mouth every 8 hours as needed for pain. Order date. 08/07/2017."

Review of the August 2017 MAR (medication administration record) documented, "HYDROmorphone HCL (hydrochloride) Tablet 2 MG (milligrams). Give 2 mg by mouth every 8 hours as needed for r/t (related to) pain related to ACQUIRED ABSENCE OF RIGHT BREAST AND NIPPLE. Order date. 08/07/2017."

An observation of medication administration to Resident #3 was made on 8/8/17 at 8:55 a.m. with LPN (licensed practical nurse) #4. Resident #3 complained of pain in her back. LPN #4 gave the resident hydromorphone 2 milligrams at that time.

Review of the nurse's note dated 8/8/17 at 9:07 a.m. documented, "Note Text: HYDROmorphone HCL Tablet 2 MG. Give 2 mg by mouth every 8 hours as needed for r/t pain related to ACQUIRED ABSENCE OF RIGHT BREAST AND NIPPLE. Resident states a pain level of 8 in her back..."

Review of the nurse's note dated 8/9/17 at 9:02 a.m. documented, "Note Text: HYDROmorphone HCL Tablet 2 MG. Give 2 mg by mouth every 8 hours as needed for r/t pain related to ACQUIRED ABSENCE OF RIGHT BREAST AND NIPPLE. Resident states a pain level of 8/10 in both knees..."

An interview was conducted with LPN #4 on 8/9/17 at 11:40 a.m. When asked to review the hydromorphone order for Resident #3, LPN #4

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stated, "I did read that yesterday." When asked where the resident's reported pain was located, LPN #4 stated, "In her back." When asked if the medication was ordered for back pain, LPN #4 stated, "No. I should have reported it to the doctor and got a clarification."

An interview was conducted with LPN #5 on 8/9/16 at 2:00 p.m. LPN #5 was asked to review Resident #3's order for hydromorphone. When asked what process the staff would follow if the resident complained of back pain but the pain medication order was for post mastectomy pain, LPN #5 stated, "Since the dilaudid (hydromorphone) is for the mastectomy site I would do non-pharmacological interventions and give the Tylenol the physician had ordered. If the Tylenol wasn't effective I would call the MD (medical doctor) to change the dilaudid order."

On 3/9/17 at 3:40 p.m. ASM #1, the interim director of nursing and ASM #2, the assistant director of nursing were made aware of the findings.

Review of the facility's policy titled, "General Dose Preparation and Medication Administration" documented in part, "4.1 Facility staff should: 4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident..."

No further information was provided prior to exit.

No further information was obtained.

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2. The facility staff failed to follow the physician's 6/16/17 order to obtain a blood glucose sample twice a day.

Resident #5 was admitted to the facility on 1/6/17 with diagnoses that included but were not limited to: diabetes, high blood pressure, irregular heart beat and peripheral vascular disease (1).

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/13/17 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) assessment indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring some assistance from staff for activities of daily living except for eating which the resident could do independently.

Review of Resident #5's care plan created on 2/22/17 documented, "Focus. The resident has Diabetes Mellitus. Interventions. Labs (laboratory test) as ordered by doctor."

Review of the physician's orders dated and signed on 6/16/17 documented, "Accuchecks (blood glucose) BID (twice a day). Call NP (nurse practitioner) if BS (blood sugar) > 250."

Review of the August 2017 MAR (medication administration record) documented, "Accucheck one time a day every Fri (Friday) Order Date 03/08/2017. Accuchecks one time a day every Mon (Monday) Order Date. 03/08/2017." It was documented that the accucheck had been obtained on Friday, 8/4/17 and Monday, 8/7/17. Further review of the MAR did not evidence documentation of the 6/16/17 order for

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accuchecks twice a day.

An interview was conducted on 8/9/17 at 9:45 a.m. with LPN #2, the interim unit manager. When asked the process staff followed to enter new orders into the resident's clinical record, LPN #2 stated, "The nurse enters the order into (name of software), and then she signs off the order." When asked to review the 6/16/17 accucheck order and the August 2017 MAR, LPN #2 stated, "The one (the order) that's in there is the one for once a day every Monday and once a day every Friday. This is an error."

An interview was conducted on 8/9/17 at 11:40 a.m. with LPN #4. When asked the process staff followed to enter physician's orders into the resident's clinical record, LPN #4 stated, "We enter the order into (name of software). Type it in exactly as it was written. I sign, date and time when I did it and leave it (the written order) in the chart."
The nurse who had signed off the accucheck order was not available for interview.

On 8/9/17 at 3:40 p.m. ASM #1, the interim director of nursing and ASM #2, the assistant director of nursing were made aware of the findings.

Review of the facility's policy titled, "Physician/Prescriber Authorization and Communication of Orders to Pharmacy" documented in part, "3.1 Authorized staff and prescribers enter prescriber orders electronically to the pharmacy."

No further information was provided prior to exit.

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F 309	Continued From page 39 1. Peripheral vascular disease -- Peripheral artery disease (P.A.D.) is a disease in which plaque builds up in the arteries that carry blood to your head, organs, and limbs. Plaque is made up of fat, cholesterol, calcium, fibrous tissue, and other substances in the blood. This information was obtained from: https://www.nhlbi.nih.gov/health/health-topics/topics/pad/	F 309		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with 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, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to promote healing of pressure ulcers for one of 24 residents in the survey sample,	F 314	F314 1. Resident #5 physician order for □float heels at all times□ was clarified and changed to □float heels when in bed□ on 8/18/2017.	8/29/17

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F 314	Continued From page 40 Resident #5. The facility staff failed to float Resident #5's heels at all times as ordered by the physician. The findings include: Resident #5 was admitted to the facility on 1/6/17 with diagnoses that included but were not limited to: partial amputation of the left foot, diabetes, high blood pressure, irregular heart beat and peripheral vascular disease (1). The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/13/17 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) assessment indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring some assistance from staff for activities of daily living but could feed self independently. The resident was coded as having a pressure ulcer on the left heel there was no other information documented. Review of the nurse's wound assessment notes dated 6/12/17 documented that the resident had a stage II pressure ulcer (2) on the left stump. Review of the care plan created on 1/6/17 and revised on 7/18/17 documented, "Focus. Actual skin impairment with potential for further skin impairment r/t (related to) immobility. Interventions. Float heels." An observation was made on 8/8/17 at 11:10 a.m. Resident #5 was sitting up in a chair next to the bed. Her feet were resting on the floor. She had a	F 314	2. All resident with floating heels orders will be reviewed to ascertain appropriateness and clarity. All identified ambiguity in any floating heels order will be clarified with the physician accordingly. 3. Re-education with the facility nursing staff to include: a. Physician orders on floating heels b. Process of completion for Braden scales and appropriate interventions c. Policy on skin assessment, pressure ulcer monitoring, and documentation. 4. The DON/designee will audit all patients with floating heels order weekly X 2 weeks, monthly X 2 months, and quarterly X 1 to ensure clarity and implementation of order accordingly. Any abnormal finding will be forwarded to the QA committee for further review and resolution.	

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dressing on her left foot.

An observation was made on 8/8/17 at 1:55 p.m. Resident #5 was sitting up in a chair next to the bed. Her feet were resting on the floor. She had a dressing on her left foot.

Review of the physician's orders dated 6/12/17 documented, "Float heels at all times > danger of limb loss."

Further review of the physician's orders dated August 2017 documented, "Float heels every shift for left heel wound. Order Date. 03/10/2017."

Review of the physician assistant's note dated 7/19/17 at 7:35 p.m. documented, "Left heel surgical wound: Scabbed, improving. Cont (continue) dressing changes."

Review of the August 2017 treatment administration record documented, "Float heels every shift for left heel wound. Order Date. 03/10/2017." It was documented that the heels were floated every shift for each day from 8/1/17 to 8/8/17.

Review of the nurse's wound care note on 8/3/17 documented the wound was 1.1 cm (centimeters).

An interview was conducted on 8/8/17 at 1:55 p.m. with Resident #5. When asked if staff assisted her with activities, Resident #5 stated, "Yes they do. When I get into bed they put pillows under my legs so I can float my heels." When asked if she floated her heels when she sat up in the chair, Resident #5 stated she did not.

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An interview was conducted on 8/9/17 at 9:45 a.m. with LPN (licensed practical nurse) #2, the interim unit manager. When asked to review the physician's order, LPN #2 stated, "Float the heels whenever in bed or even when she's up in the wheelchair. They don't want her legs to be hanging." When asked why the physician didn't want the resident's legs to be hanging, LPN #2 stated, "For possible limb loss. She has PVD (peripheral vascular disease) and she already has had an amputation on one of her legs."

An observation was made on 8/9/17 at 9:50 a.m. of Resident #5 with LPN #2. The resident was sitting in a chair next to the bed with her legs dangling down and her feet resting on the floor. LPN #2 stated, "I see, she needs to have her legs elevated."

An interview was conducted on 8/9/17 at 11:00 a.m. with LPN #3, the resident's nurse. When asked to review the physician's order to float the heel at all times, LPN #3 stated, "I'm not 100 percent sure about that but I will check." LPN #3 returned shortly and stated, "Usually we only float heels when they are in the bed so we are going to clarify that order because she can move her limbs completely."

A wound care observation was made on 8/9/17 at 11:10 a.m. with LPN (licensed practical nurse) #3. The dressing was removed from Resident #5's left foot stump. The toes and part of the foot had been amputated, there was a healed incision extending across the top of the foot stump. LPN #3 had Resident #5 raise her leg and there was a round wound observed on the posterior aspect of the ankle measuring 1 cm (centimeter) by 1.2 cm by 0.2 cm. The wound was dry. When asked how

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the wound occurred, Resident #5 stated, "The ace wrap was too tight and it caused the sore." The nurse completed wound care as ordered by the physician. LPN #3 and Resident #5 reported the wound was improving.

An interview was conducted on 8/9/17 at 2:00 p.m. with LPN #1. When asked to review the physician's order to float Resident #5's heels at all times, LPN #1 stated, "I would contact the doctor who wrote those orders because that's not a clear order. You always clarify (orders) with the doctor. That's nursing 101."

On 8/9/17 at 3:25 p.m. ASM (administrative staff member) #2, the interim director of nursing, and ASM #3, the assistant director of nursing, were made aware of the findings.

On 8/9/17 at 4:25 ASM #4 was asked what professional standard the facility used, ASM #4 stated, "Potter and Perry."

Review of the facility's policy titled, "Physician's Orders" did not evidence documentation regarding following physician's orders.

No further information was provided prior to exit.

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

1. Peripheral vascular disease -- Peripheral artery

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F 314	Continued From page 44 disease (P.A.D.) is a disease in which plaque builds up in the arteries that carry blood to your head, organs, and limbs. Plaque is made up of fat, cholesterol, calcium, fibrous tissue, and other substances in the blood. This information was obtained from: https://www.nhlbi.nih.gov/health/health-topics/topics/pad/ 2. Stage II pressure ulcer -- Category/Stage II: Partial thickness skin loss or blister Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Further description: Presents as a shiny or dry shallow ulcer without slough or bruising. This category/stage should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation. This information was obtained from: http://www.npuap.org/wp-content/uploads/2012/03/Final_Quick_Treatment_for_web_2010.pdf	F 314		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 371		8/29/17

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F 371	Continued From page 45 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to store food in a sanitary manner. The facility staff failed to label the prepare date of three trays of peanut butter sandwiches, one tray of salad, one tray of peaches, one tray of grapes and two trays of pudding cups that were sitting on a rack in the kitchen refrigerator. The facility staff failed to label the use-by-date of an open gallon tub of ranch dressing; and failed to discard a honey dew melon and five cartons of strawberries that were growing mold. The findings include: On 8/8/17 at 7:20 a.m., observation of the kitchen was conducted. On 7:20 a.m. inspection of the first refrigerator was conducted. A rack of premade food was observed with three trays of peanut butter sandwiches, one tray of salads in bowls, one tray of peaches in bowls, one tray of grapes in bowls, and two trays of pudding in	F 371	F371 1. Three trays of peanut butter sandwiches, one tray of peaches, one tray of grapes, two trays of pudding cups, one-gallon tub of ranch dressing, one honey dew, and five cartons of strawberries were immediately discarded on 8/8/2017. 2. All food storage areas were inspected and any food items not appropriately labeled were immediately discarded on 8/8/2017. 3. Re-education with facility staff by Corporate Dietitian to include: a. Policy and procedure for proper food storage 4. The Corporate Dietitian/Center Dietitian/designee will audit all available food storage areas at the Center weekly X 2 weeks, monthly X 2 months, and quarterly X 1 to ensure they have no expired/unlabeled food/produce with mold. Any noted expired/unlabeled/molded food item will	

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bowls. All food items were covered with a lid. There was no date on these items to determine when they were prepared.

On 8/8/17 at 7:22 a.m., an interview was conducted with OSM (other staff member) #3, the dietary aide. When asked when the above food items were prepared, OSM #3 stated that the above food items must have been prepared yesterday (8/7/17) because they did not prepare it that morning. OSM #3 stated, "We usually trash the peanut butter and jelly because see how it's hard?" When asked if the trays of food items should be labeled with a date of when they were prepared, OSM #3 stated, "Yes, I guess we are supposed to."

On 8/8/17 at 7:30 a.m., inspection of the second refrigerator was conducted. A gallon tub of ranch dressing was observed opened. A use-by-date or open date could not be found on the tub. A honey dew melon and five cartons of strawberries were also observed to be growing mold.

On 8/8/17 at 7:33 a.m., an interview was conducted with OSM #2, the cook. When asked when the tub of ranch was opened, OSM #2 stated that he was not sure. OSM #2 confirmed that there was no open date or use-by-date on the tub of ranch. OSM #2 stated that all food should be labeled when opened. OSM #2 also confirmed that mold was growing on the honey dew melon and the five cartons of strawberries. OSM #2 stated that the produce should have been discarded. When asked how often dietary staff checks the refrigerator for expired or moldy items, OSM #2 stated, "Sometimes produce comes off the truck moldy so it should have been labeled if it needed to be sent back." OSM #2

discard immediately. Finding will also be forwarded to the QA committee for further review and recommendation.

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could not determine how often staff check the refrigerator or expired items. OSM #2 stated that they had lost their dietary manager the week prior.

On 8/9/17 at 12:10 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator and OSM #4, the corporate dietary manager. OSM #4 stated that all food items should be labeled before they go into the refrigerator. OSM #4 stated that food items should also be labeled with a use-by-date. OSM #4 stated that the facility had used the ranch dressing to make a recipe the weekend prior. OSM #4 stated that she could not prove that was when the ranch was opened. OSM #4 also stated that the rack of food items was probably prepped the day before (8/7/17). OSM #4 stated, "We usually prep food the day before. It is never done more than one day before it will be served." When asked how often the refrigerator was checked for expired or moldy food items, OSM #4 stated, "Every day the staff are in the refrigerator." OSM #4 stated that dietary staff should be checking the produce each time they go into the refrigerator.

On 8/9/17 at 12:53 p.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing), ASM #3, the ADON (Assistant Director of Nursing) and ASM #4, the nurse consultant were made aware of the above concerns.

Facility policy titled, "Refrigerated and Frozen Food" documents in part, the following, "Foods stored in the refrigerator or freezer will be stored in a manner which maintains the food so that it is safe to eat, and retains optimal nutrient content and aesthetic quality...2. All refrigerated and

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F 371	Continued From page 48 frozen food containers will be labeled, indicating the name of the product and use-by-date. 3. All refrigerated and frozen foods will be used or discarded by the use-by-date indicated on the manufacturer's label. Frozen foods will be used or discarded within (6) months of receipt if no manufacturer use-by-date is listed on the package. For refrigerated foods, if no manufacturer use-by-date is listed on the package, the Refrigerator Food Storage Schedule will be used." No further information was presented prior to exit.	F 371		
F 504 SS=D	LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN CFR(s): 483.50(a)(2)(i) (a) Laboratory Services (2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. 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 obtain a physician order prior to obtaining a laboratory test for one of 24 residents in the survey sample, Resident #13. The facility staff obtained completed two laboratory tests for Resident #13, without a physician order.	F 504	F504 1. Resident #13 physician was notified on 8/9/2017 of the labs obtained on 10/14/2016 without order. 2. All lab results from 10/14/2016 for current residents will be reviewed to ascertain corresponding physician□s orders. Affected resident□s physician will be notified of any lab result noted without an order.	8/29/17

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F 504	Continued From page 49 The findings include: Resident #13 was admitted to the facility on 9/11/14 with diagnoses that included but were not limited to: benign neoplasm (non-cancerous tumors) of the brain and bladder, seizures, diabetes, intellectual disability, dementia, schizophrenia, high blood pressure and paraphilia * Paraphilia is a recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving i) non-human objects, ii) the suffering or humiliation of oneself or one's partner, or iii) children or other non-consenting persons that occur over a period of at least 6 months. (1) The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/23/17 coded the resident as scoring a nine on the BIMS (brief interview for mental status score), indicating he was moderately impaired to make cognitive daily decisions. Resident #13 was coded as being independent or requiring supervision for most of his activities of daily living. The resident was coded as requiring more assistance for personal hygiene and bathing. Resident #13 was coded as ambulating on and off the unit independently with the use of a cane. Review of the clinical record was conducted on 8/8/17. A copy of a laboratory test dated 10/14/16 revealed the results were for the following levels: BMP (basic metabolic panel), (A metabolic panel is a group of tests that measures different chemicals in the blood. These tests are usually done on the fluid [plasma] part of blood. The tests	F 504	3. Re-education with the facility nursing staff to include: a. Process for obtaining labs from patients b. Policy for laboratory/diagnostic testing. 4. The DON/designee will audit 10% of recent lab results of current residents weekly x2 weeks, monthly x2 months, and quarterly x1 for the presence of corresponding laboratory orders. Any deviation noted will be forwarded to the QA committee for further review and resolution.	

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provide information about your body's chemical balance and metabolism. They can give doctors information about your muscles [including the heart], bones, and organs, such as the kidneys and liver (2)).

HgA1C (hemoglobin A 1 C) - (HbA1c is a lab test that shows the average level of blood sugar [glucose] over the previous 3 months. It shows how well you are controlling your diabetes. Alternative Names include: Hemoglobin - glycosylated; A1C. (3))

Carbamazepine level - (Carbamazepine is an anticonvulsant used to control grand mal and psychomotor or focal seizures - this test measures for the level in the blood stream (4)).

Review of the clinical record failed to evidence a physician order for the BMP, HgA1C and Carbamazepine level.

A request for the physician order for the above laboratory test results was made of to the administrator on 8/9/17 at 9:16 a.m.

The comprehensive care plan dated, 4/29/16 documented in part, "Focus: CARE NEEDS: Related to HTN (high blood pressure), constipation, DM (diabetes mellitus) personal history of Mental and Behavioral disorders, unspecified convulsions (seizures), and unspecified intellectual disabilities." The "Interventions" documented in part, "Monitor labs (laboratory tests) as ordered." This intervention was dated 4/29/16.

On 8/9/17 at 11:02 a.m. ASM (administrative staff member) #4, the nurse consultant, presented an

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F 504	Continued From page 51 order dated 10/14/16 for the HgA1C level. He stated he could not locate an order for the BMP or Carbamazepine level. When asked if a physician order is required for any laboratory tests, ASM #4 stated, "Yes." The facility policy, "Laboratory/Diagnostic Testing" documented in part, "1. A licensed nurse will obtain laboratory, radiology or other diagnostic services to meet the needs of its patients as ordered by the physician or physician extender." ASM #1, ASM #2, the interim director of nursing, ASM #3, the assistant director of nursing and ASM #4, the nurse consultant, were made aware of the above concern on 8/9/17 at 12:47 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3769077/ (2) This information was obtained from the following website: https://medlineplus.gov/metabolicpanel.html (3) This information was obtained from the following website: http://www.nlm.nih.gov/medlineplus/ency/article/003640.htm. (4) This information was obtained from the following website: https://pubchem.ncbi.nlm.nih.gov/compound/carbamazepine#section=Top	F 504		
F 514	RES	F 514		8/29/17

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F 514 SS=D	Continued From page 52 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed 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	F 514	F514	

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and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate medical record for one of 24 residents in the survey sample, Resident #5.

The facility staff failed to accurately document Resident #5's behaviors on 24 occasions out of 126 opportunities.

The findings include:

Resident #5 was admitted to the facility on 1/6/17 with diagnoses that included but were not limited to: partial amputation of the left foot, diabetes, high blood pressure, irregular heart beat and peripheral vascular disease (1).

The most recent MDS (minimum data set, a quarterly assessment, with an ARD (assessment reference date) of 7/13/17 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) assessment indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring some assistance from staff for activities of daily living but could feed self independently.

Review of the care plan created on 8/8/17 documented, "Focus. Resident has a potential to display the following behaviors: INCREASE IN COMPLAINTS, REFUSING CARE. Intervention. OFFER DRINK/SNACK...."

Review of the physician's orders dated August 2017 documented, "BEHAVIORS -- MONITOR FOR THE FOLLOWING: INCREASE IN COMPLAINTS, REFUSING CARE. Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed,

1. Resident #5 behavior documentation was reviewed and physician notified of the 24 missing behavior documentation out of 126 opportunities on 8/16/2017. No new order was given by the physician
2. All patients with behavioral monitoring orders reviewed to ascertain accurate documentation of all behavior incidents noted on the MAR and adequately followed-up by the staff
3. Re-education of nursing staff on the following:
a. Resident behavioral management
b. Appropriate behavioral documentation and follow-up
c. Entering behavior monitoring order and daily documentation on the MAR/progress note.
4. DON/Designee will audit 10% of the behavior document record of current residents with behavior monitoring orders weekly x2, monthly x2, and quarterly x1 to ascertain adequate documentation and follow-up. Any anomaly noted will be rectified accordingly. Finding will also be forwarded to the QA committee for further review and recommendation.

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select chart code 'Other/See Nurses Notes' and progress note findings every shift related to ANXIETY DISORDER UNSPECIFIED. Order Date. 08/08/2017."

Review of the July and August 2017 MAR (medication administration record) documented, "BEHAVIORS -- MONITOR FOR THE FOLLOWING (specify) ITCHING, PICKING AT SKIN, RESTLESSNESS (AGITATION), HITTING, INCREASE IN COMPLAINTS, BITING, KICKING, SPITTING, CUSSING, RACIAL SLURS, ELOPEMENT, STEALING DELUSIONS, HALLUCINATIONS, PSYCHOSIS, AGGRESSION, REFUSING CARE. Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/See Nurses Notes' and progress note findings every shift related to ANXIETY DISORDER UNSPECIFIED. Order Date. 02/17/2017. D/C (discontinue) Date. 08/08/2017."

Further review of the July 2017 MAR revealed documentation of an "N" on 24 shifts indicating that the resident had exhibited these behaviors.

Review of the nurse's notes for July 2017 did not evidence documentation regarding the resident's behavior.

Review of the August 2017 MAR revealed documentation of an "N" on one shift indicating that the resident had exhibited some behaviors on one shift during the month. Review of the nurse's notes from 8/1/17 through 8/8/17 did not evidence documentation regarding the resident exhibiting any of these behaviors.

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An interview was conducted on 8/9/17 at 9:45 a.m. with LPN (licensed practical nurse) #2, the interim nurse manager. When asked the process staff followed to document resident's behaviors, LPN #2 stated, "If there aren't any behaviors, they document a 'Y'. If the resident has behaviors, they document a 'N' It's very confusing. I may have to do an in-service for the staff about it." When asked if there was documentation that a resident was exhibiting the behaviors, LPN #2 stated, "Yes, you have to write a progress note." When asked to review the nurse's notes for Resident #5's behaviors, LPN #2 stated, "She doesn't have any behavior notes and from my knowledge she doesn't have any behaviors. I'm wondering if they're (the nurses) are getting confused (on how to correctly document on the MAR)."

An interview was conducted on 8/9/17 at 3:30 p.m. with LPN #6, a nurse who documented that Resident #5 exhibited behaviors. When asked to review her documentation on the July and August 2017 MARs for behaviors on Resident #5, LPN #6 stated, "That shouldn't be a no, it should be a yes because she doesn't have behaviors. I don't know how that happened because when you press no it (the software) wants you to put in a progress note or it won't let you save it." When asked to review Resident #5's nurse's notes for July and August 2017, LPN #6 stated, "There's nothing there. She doesn't have behaviors. We check behaviors on all of our residents just in case they have a change in behavior." When asked if it was important to have accurate documentation in a resident's clinical record, LPN #6 stated it was because other staff would be aware of a resident's condition.

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Attempts were unsuccessful to contact another nurse who had documented "N" on the MAR. On 8/9/17 at 3:40 p.m. ASM (administrative staff member) #1, the interim director of nursing and ASM #2, the assistant director of nursing were made aware of the findings.

Review of the facility's policy titled, "Documentation Requirements" did not address maintaining a complete and accurate clinical record.

No further information was provided prior to exit.

The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients." Potter and Perry (2005) also includes, the following information: "As members of the health care team, nurses need to communicate information about clients accurately and in a timely, effective manner."

1. Peripheral vascular disease -- Peripheral artery disease (P.A.D.) is a disease in which plaque builds up in the arteries that carry blood to your head, organs, and limbs. Plaque is made up of fat, cholesterol, calcium, fibrous tissue, and other substances in the blood. This information was

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