STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495174		C 07/27/2017

NAME OF PROVIDER OR SUPPLIER
DULLES HEALTH & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
2978 CENTREVILLE ROAD
HERNDON, VA 20171

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	An unannounced Medicare/Medicaid standard survey was conducted on 7/24-7/27/2017. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety survey/report will follow. The census in this 166 certified bed facility was 161 at the time of the survey. The survey sample consisted of 22 current residents (Residents 1-18 and 26-29) and 9 closed residents (Residents 19-25 and 30-31).			
F 157 SS=E	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 157		9/5/17

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

Electronically Signed — 08/17/2017

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

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F 157	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record review, and in the course of a complaint investigation, the facility staff failed for four residents, (Resident #19, #20, #12, and #21) in a survey sample of 31 residents, to notify the physician of a significant change in condition. 1. The facility failed to notify the physician of unavailability of physician ordered pain medication for Resident #19. 2. For Resident #20 the facility staff failed to	F 157	1. It is duly noted that the physician was not notified of pain medications that were not available for Resident #19, a change of condition for Resident #20, medication and tube feeding/water flush omissions as well as other medication omissions for Resident #21 and medication omission from resident #12. Resident #'s 19, 20, and 21 were all discharged from the facility. Resident #12's physician was notified of the need for clarification of route of medication, omission of	

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F 157	Continued From page 2 notify the physician of a change in condition. 3. For Resident #12 the physician was not notified of medication omissions. 4. For Resident #21 the physician was not notified of medication omissions. The findings included: 1. The facility failed to notify the physician of unavailability of physician ordered pain medication for Resident #19. Resident #19 was admitted to the facility 2/20/17. Diagnoses included asthma, recent right knee replacement and sleep apnea. The resident arrived at the facility on 2/20/17 at 8:30 PM. The resident left the facility on 2/21/17 and was admitted to the hospital. A comprehensive MDS (minimum data set) was not completed for this resident, but a Medicare five day assessment with an ARD (assessment reference date) of 2/21/17 coded the resident as having no short or long term memory loss. The resident required extensive to total assistance of one staff member for bed mobility and transferring. Review of the resident's MAR (medication administration record) for February, 2017, included the following medication orders for pain: Gabapentin (nerve pain) 300 mg (milligrams) twice daily. The 2/20/17 evening dose was not documented as given. Norco tablet 10/325 mg every 4 hours as needed	F 157	medication, omission of enteral feeding and hydration on 7/26/17 with new orders initiated. 2. Any resident receiving medications and tube feedings/water flushes or who experience a change of condition has the potential to be affected if the physician is not notified of medications not administered as ordered or unavailable medications, as well as changes of condition. An audit will be done of the EMAR, ETAR, and progress notes to ensure that medications and enteral feedings not administered as ordered as well as changes of condition were communicated to the physician beginning from 8/7/17 with corrective actions taken as needed. 3. The licensed nurses will be re-educated to notify the physician if medications or other orders are unable to be carried out as given and if the patient/resident experiences a change of condition. 4. The DON/designee will audit the EMAR, ETAR and progress notes for medication not available, medication omissions and changes of condition to ensure the physician was notified daily 5 days per week for 4 weeks, then weekly x 8 weeks. The results of the audits will be forwarded to the QAPI committee for review.	

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F 157	Continued From page 3 for pain. Norco (Percocet) is a opoid schedule II narcotic used for mild to moderately severe pain. There was no documentation that this medication was given during the resident's stay. The nurses notes dated 2/20/17 at 10:55 PM read as followed: "She stated pain on a scale of 0 to 10 was 5. Prn (as needed) pain med Tylenol 2 tabs given." There was no follow up documented as to the effectiveness of the Tylenol. The next nurses note was dated 2/212/17 at 7:21 AM, which read: "Resident is alert and oriented x 3 new admit day 1/3 no complaints noted. On c-pap no signs or symptoms of respiratory distress, surgical wound to right leg with dressing intact, visible bleeding noted on dressing no signs or symptoms of of infection noted." The last nurses note dated 2/21/17 at 10:24 AM noted, "Resident alert and oriented x 3, new admit day 1/3, complain (sic) of right knee on a pain scale of 4/10. Prn Norco and Ativan (antianxiety) at 9:20 AM.... right knee surgical site noted bleeding with some redness, area is warm to touch, call paced to MD.. Patient insist she go to the hospital...transferred at 10:30 AM. Vital signs: Temperature 99.0, heart rate 81, respirations 20 and blood pressure 106/51, O 2 sat (oxygen in blood) 98% on room air." Review of the initial nursing assessment dated 2/21/17 revealed, "the resident reported pain frequently in the last 5 days, which made it harder to sleep." It was also noted on the assessment the resident had been taking Percocet. Review of the Emergency Room records and the assessment and plan dated 2/21/17 by the nurse practitioner revealed "Intractable pain, poor pain control at the SNF (skilled nursing facility)."	F 157		

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F 157	Continued From page 4 The History and Physical documented on 2/21/17 contained the following: "Patient did not have the expected care and follow up in the SNF that she was in. Patient states she did not get any pain medication, her knee was accidentally bumped, and that started bleeding, making the pain worse and per patient did not receive any pain meds for that either. Patient had to be brought back to the hospital for pain management." On 7/26/17 at 10:00 AM, a phone interview was conducted with LPN (licensed practical nurse A). LPN (A) was asked about why the resident did not receive her physician ordered Percocet during the night. LPN (A) stated, "I was told the medication would be delivered in the morning as we did not have the medication available." She went on to state the resident was given Tylenol at 8:30 PM and she slept until 5:30 AM or 6:00 AM. The pain level documented at this time was "5" on a scale of 0-10. There was no documentation of the effectiveness of the Tylenol. She continued that the resident did not have any complaints and did not call for anything. LPN A then stated, "I handed it over to the day nurse to give right now." The Percocet and Ativan were given to the resident on 2/21/17 at 9:20 AM. On 7/26/17 at 10:30 AM, the DON (director of nursing) was asked for the list of stat (emergency) medications, including narcotics, available for emergency use. The list did contain the physician ordered Percocet. On 7/27/17 at 11:00 AM, the DON was asked what the nurse should have done to ensure the resident received her pain medication. She stated, "She should have called the physician to	F 157		

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F 157	Continued From page 5 let him know it was unavailable so he could order something else." Complaint deficiency 2. For Resident #20, the facility staff failed to notify the physician of a change in condition. Resident #20 was an 83 year old who was admitted to the facility on 12/28/16, and discharged home 1/9/17. Resident #20's diagnoses included Right Femur Fracture upon admission, Muscle Weakness - Generalized, Hypertension, Incontinence of Bowel, and Incontinence of Bladder. The Minimum Data Set, which was an Admission Assessment with an Assessment Reference Date of 1/4/17, coded Resident #20 as having a brief Interview of Mental Status Score of 3, indication severe cognitive impairment. In addition, he was coded as being frequently incontinent of bowel and bladder. On 7/25/17 a review was conducted of Resident #20's clinical record, revealing a Nurse's Progress Note dated 1/7/17 at 6:47 P.M. It read, "This nurse was called to the room by the daughter, observed the pt. (patient) in the shower chair not verbally responding to the daughter's voice, the pt's mouth was moving as if he wanted to speak but was not able to verbalize, sternal rub initiated with no response, this occurred for about 2-3 mins, vital obtained and the pt began to speak (entire time of the incident was 3-4 min) pt then began to speak and answer questions, b/p(blood pressure) was taken prior to being transfer reading; 101/66 with 66 pulse with 66	F 157		

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F 157	Continued From page 6 pulse, when this episode occurred and b/p taken it was 92/59, with 69 pulse, oxygen 99% room air, pt is now in the bed with daughters at bedside, only ate small bites of dinner for the family, alert and cognition is at baseline." The nurse who wrote this note was not available to be interviewed. There was no facility documentation of Resident #20's physician being contacted regarding his change in condition. On 7/26/17 an investigation was conducted of a complaint submitted by Resident #20's daughter on 7/6/17. It read, "The complainant states her father had what appeared to be a seizure; he was never evaluated by the physician." On 7/27/17, the Administrator (Employee A), and Director of Nursing (Employee B) were informed of the findings. No further information was received. 3. For Resident #12 the physician was not notified of medication omissions. Resident #12 was admitted to the facility on 7-19-17. Diagnoses for Resident #12 included but were not limited to; Gastrostomy tube for feeding and medication administration, stroke, hypertension, atrial fibrillation, hypothyroidism, high cholesterol, osteoporosis, prosthetic heart valve, and transient ischemic attacks. Resident #12's most recent Minimum Data Set (MDS), was not yet completed, as the Resident had not been in the facility a full week upon entrance to the survey. Review of nursing notes, observation,	F 157		

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F 157	Continued From page 7 and the initial care plan indicated that the Resident required extensive assistance for all Activities of Daily Living care. On 7-26-17 beginning at 8:30 a.m., surveyor observations were conducted, by 2 surveyors. From 8:30 a.m., until 11:00 a.m. no tube feeding was infused. The Resident was laying in bed clothed. At 11:00 a.m. the Resident's spouse came in to take the Resident out for a neurological appointment. The mechanical pump which instilled the feeding was at bedside turned off, and when turned on, showed no history of the last infusion. A review of Resident #12's clinical record was conducted during the survey. The review showed five current tube feeding physician's orders dated 7-19-17. The orders read that Resident #12 was to have the following; 1. "Two times a day Isosource HN @ 75 ml/hr (milliliters per hour) x 16 hours (1200 ml) up at 1800 (6:00 p.m.) down at 1000 (10:00 a.m.)." 2. "Continuous feeding: check residual every 8 hours. If 100 ml (milliliters) or over, hold feeding for one hour and recheck: If residual 100 ml or over, notify the physician. Document amount of residual every shift." 3. "Document Intake every shift". 4. "Two times a day 40 ml H2O (water) every hour x 16 hours (640 ml) with enteral feeding." up at 6:00 p.m., and down at 10:00 a.m." 5. NPO (nothing by mouth)	F 157		

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F 157	Continued From page 8 A review of Resident #12's Medication and Treatment Administration Records (MAR/TAR) for July 2017, revealed that Resident #12 did not have a residual check for the continuous feeding on 7-24-17 in the morning, nor that evening. The nurse placed an "X" in the area designated for residual amount in the morning, and did not sign the MAR at all for the evening. There were no nursing notes to explain the omissions. On the second order, for intake documentation, there was no documentation of any intake on 7-24-17 on evening, or night shifts. On 7-26-17 there was no documentation for the day shift, of the feeding amount even though the feeding had been discontinued prior to 8:30 a.m.. On 7-26-17 the feeding order was signed at 10:00 a.m., as if the full administration of feeding had occurred, however, surveyors observed no feeding infusing from 8:30 a.m. through 10:00 a.m., a loss of 112.5 ml of feeding, and 60 ml of water. The MAR further revealed that on 7-20-17 Levothyroxine for hypothyroidism was administered in the morning via the gastrostomy tube, and Leflunomide for Rhematoid Arthritis was not administered, nor noted in the nurse notes. The MAR states "other/see nurse notes" for both medications. The nursing notes stated "refused to open mouth." The Resident was NPO. On 7-26-17 at approximately 4:00 p.m., an interview was conducted with the Director of Nursing (DON), and Administrator, and they were made aware of the absence of feeding and hydration at the above observations. The DON and Administrator stated they would look into the issue. The facility policy on medication administration	F 157		

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F 157	Continued From page 9 stated "give medications as ordered." On 7-27-16, the DON entered with the unit manager RN (Registered Nurse) C, who stated the nurse had just taken the feeding down the previous day at 9:00 a.m. because they were allowed a window of 1 hour before and 1 hour after the stated order time to administer medications. It was explained at that time that this "allowance" in the standards was for medication administration which had no effect on potency of a drug, however, that is not true of calorie intake, and water intake. Omissions of over an hour of tube feeding, and water occurred as the feeding had not been infusing at 8:30 a.m. The reason for the 16 hour order, was to meet the required caloric, and hydration needs of this Resident. The Director of Nursing gave "Lippincott" as the standard for nursing practice in the facility. "Fundamentals of Nursing, by Lippincott", provides guidance for nursing standards. The reference stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients." The facility administration was informed of the findings during the end of day debriefing on 7-26-17 at 5:00 p.m., and 7-27-17 at 11:00 a.m. No further evidence was able to be provided by the facility. 4. For Resident #21 the physician was not notified of medication omissions.	F 157		

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F 157	Continued From page 10 Resident #21 was admitted to the facility on 12-17-16. Diagnoses for Resident #21 included but were not limited to; congestive obstructive pulmonary disease (COPD), Oxygen dependence, sleep apnea, Pleural effusion, congestive heart failure, obesity, Gastroesophageal reflux disease, hypertension, diabetes, depression, and chronic kidney disease. Resident #21's most recent Minimum Data Set (MDS), was an admission assessment with an ARD (assessment reference date) of 12-24-16. The resident was coded as having no cognitve impairment, and required extensive to total assistance on staff for activities of daily living such as dressing, and bathing. The Resident was discharged home on 1-23-17 (37 day stay), and so a closed record review was conducted. A review of Resident #21's clinical record was conducted during the survey. The review showed four physician's orders that were not administered as ordered by the physician. The orders read that Resident #21 was to have the following; 1. "Atorvastatin tab 20 mg (milligrams) give 0.5 tablet by mouth at bedtime for HLD (high cholesterol) give total of 10 mg." To be administered at 9:00 p.m. 2. "Prednisone 5 mg give 2 tablets by mouth one time per day for COPD for 3 days." To be administered at 9:00 a.m. 3. "O2 (oxygen) at 2-3 liters per minute via nasal cannula, continuously every shift for shortness of breath". Which the Resident used at home and was admitted to the hospital, and nursing facility with due to acute respiratory distress and	F 157		

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F 157	Continued From page 11 hypoxia. 4. "Ipratropium-Albuterol (hand held nebulizer) solution 0.5-2.5 (3) mg per 3 ml. Give 3 ml inhale orally every 4 hours around the clock". A review of Resident #21's Medication and Treatment Administration Records (MAR/TAR) for December 2016, and January 2017, revealed that Resident #21 did not receive Atorvastatin on 12-18-16, prednisone on 12-21-16, and 12-22-16, Oxygen 12-17-16, 12-18-16, and part of 12-19-16, and Ipratropium-Albuterol (hand held nebulizer) 1-1-17, and 1-3-17 at 1:00 a.m. both times, musing notes stated "asleep and comfortable", and was not even attempted. No notes describe why these medications were omitted, and no indication is documented that the doctor was ever made aware of the omissions. On 7-26-17 at approximately 4:00 p.m., an interview was conducted with the Director of Nursing (DON), and Administrator, and they were made aware of the absence of the medications and oxygen. The DON and Administrator stated they would look into the issue. The facility policy on medication administration stated "give medications as ordered." The Director of Nursing gave "Lippincott" as the standard for nursing practice in the facility. "Fundamentals of Nursing, by Lippincott", provides guidance for nursing standards. The reference stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients."	F 157		

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F 157	Continued From page 12 The facility administration was informed of the findings during the end of day debriefing on 7-26-17 at 5:00 p.m., and 7-27-17 at 11:00 a.m. No further evidence was able to be provided by the facility.	F 157		
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 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:	F 225		9/5/17

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F 225	Continued From page 13 (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 corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, the facility staff failed to investigate and report to the state agency an injury of unknown origin for Resident #2. 1. Resident #2 was sent to the hospital with a	F 225	1. It is duly noted that the investigation and report to the state agency was not completed by the facility for Resident #2's fractured right hip. Facility will attempt to investigate resident # 2 injury of unknown origin, of fractured right hip.	

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F 225	Continued From page 14 fractured hip and an investigation was not conducted and a report was not sent to the state agency. Findings included: Resident #2, an 87 year old male, was admitted to the facility on 7/9/2016 and readmitted on 12/19/2016. His diagnoses included deep vein thrombosis, chronic kidney disease, anemia, dementia, benign prostate hypertrophy, TIA (transient ischemic attack), and hypertension. Resident #2's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/6/2017 was coded as a quarterly assessment. Resident #2 was coded as having severe cognitive impairment by a staff assessment. He was coded as needing extensive assistance of one person for his activities of daily living, and as being always incontinent of bowel and bladder. A clinical record review was conducted on 7/24/2017 at 4:15 PM and it revealed the following progress notes: 11/21/2016 12:27 PM-"Called to room by CNA (Certified Nursing Assistant). Edema observed in right hip and bruise observed in upper right leg. Resident complains of pain when touched. Order received for x-ray." 11/21/2016 11:22 PM-"X-ray result faxed to MD. New order received to send Resident to hospital via 911. 11/22/2016 12:04 AM-" ...patient x-ray shows fracture on right hip".	F 225	2. Any resident has the potential to be affected if injuries of unknown origin are not investigated and reported to the state agency as per regulation. An audit will be done of the EHR to ensure that any injury occurring to a patient/resident has been appropriately investigated and reported to the state agency as needed beginning 8/7/17. 3. The licensed staff will be re-educated regarding facility policy and procedures for documentation and investigation of any injury that occurs to the residents/patients as well as the requirement for notification to the state agency to ensure abuse of the resident/patient has not occurred. 4. The Administrator/designee will audit the EHR for any injury occurring to the residents to ensure documentation and investigation is done according to facility protocol and the state agency is notified as required daily 7 days per week for 4 weeks, then weekly x 8 weeks. The results of the audits will be forwarded to the QAPI committee for review. 5. AOC: 9/5/17	

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F 225	Continued From page 15 The results of Resident #2's x-ray were: 1. Osteopenia (lower than normal bone density) 2. Acute prominently deformed intertrochanteric fracture of the hip without dislocation. On 7/26/2017 at 10:00 AM this incident investigation report was requested. Administration A, Facility Administrator, stated that there was no report. She felt that an investigation was not necessary since Resident #2 had osteopenia, and that she considered the fracture pathological in nature. She was informed that there was no investigation and therefore the cause of the fracture remains unknown. An investigation of an injury of unknown origin was required along with a FRI (Facility Reported Incident) to the Office of Licensure and Certification. The administration was informed of findings on 7/27/2017 at 11:00 AM.	F 225		
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	F 226		9/5/17

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F 226	Continued From page 16 (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 documentation review, clinical record review the facility staff failed to operationalize the facility abuse policy for Resident #2. 1. Resident #2 was sent to the hospital with a fractured hip and an investigation was not conducted and a report was not sent to the state agency per the facility abuse policy. Findings included: Resident #2, an 87 year old male, was admitted to the facility on 7/9/2016 and readmitted on 12/19/2016. His diagnoses included deep vein thrombosis, chronic kidney disease, anemia, dementia, benign prostate hypertrophy, TIA	F 226	1. It is duly noted that the facility failed to follow its abuse policy and procedure as it pertains to the investigation and reporting of the injury of unknown origin for Resident #2. Facility will follow policies and procedures regarding abuse investigation and reporting. 2. Any resident has the potential to be affected if the facility fails to follow its abuse policy and procedure for investigating injuries and reporting to the state agency as required. An audit will be done of the EHR to ensure that any injury occurring to a patient/resident has been appropriately investigated and reported to the state	

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F 226	Continued From page 17 (transient ischemic attack), and hypertension. Resident #2's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/6/2017 was coded as a quarterly assessment. Resident #2 was coded as having severe cognitive impairment by a staff assessment. He was coded as needing extensive assistance of one person for his activities of daily living, and as being always incontinent of bowel and bladder. A clinical record review was conducted on 7/24/2017 at 4:15 PM and it revealed the following progress notes: 11/21/2016 12:27 PM-"Called to room by CNA (Certified Nursing Assistant). Edema observed in right hip and bruise observed in upper right leg. Resident complains of pain when touched. Order received for x-ray." 11/21/2016 11:22 PM-"x-ray result faxed to MD. New order received to send Resident to hospital via 911." 11/22/2016 12:04 AM-" ...patient x-ray shows fracture on right hip". The results of Resident #2's x-ray were: 1. Osteopenia (lower than normal bone density) 2. Acute prominently deformed intertrochanteric fracture of the hip without dislocation. On 7/26/2017 at 10:00 AM this incident investigation report was requested. Administration A, Facility Administrator, stated that there was no report. She felt that an	F 226	agency as needed beginning 8/7/17. 3. The licensed staff will be re-educated regarding facility policy and procedures for documentation and investigation of any injury that occurs to the residents/patients as well as the requirement for notification to the state agency to ensure abuse of the resident/patient has not occurred. 4. The Administrator/designee will audit the EHR for any injury occurring to the resident to ensure documentation and investigation is done according to facility protocol and the state agency is notified as required daily 7 days per week for 4 weeks, then weekly x 8 weeks. The results of the audits will be forwarded to the QAPI committee for review. 5. AOC: 9/5/17	

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F 226	Continued From page 18	F 226		
	investigation was not necessary since Resident #2 had osteopenia, and that she considered the fracture pathological in nature. She was informed that there was no investigation and therefore the cause of the fracture remains unknown. The facility "Abuse Prevention" policy stated: "V. Investigation-The facility will investigate and report incidents or occurrences in accordance with federal and state guidelines." "VII. Reporting/ Response- The Facility Administrator, DON (Director of Nursing), or designee must report all alleged incidents of abuse, neglect, exploitation, or mistreatment including injuries of unknown origin. If there is an allegation of abuse or injury of unknown source that results in serious bodily injury to the resident, a report must be filed with the Office of Licensure and Certification within 2 hours of the allegation." The administration was informed of findings on 7/27/2017 at 11:00 AM.			
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 (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.	F 280		9/5/17

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F 280	Continued From page 19 (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 (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--	F 280		

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F 280	Continued From page 20 (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 staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan. Resident #22's care plan listed her as a Full Code, however the code status order had been changed to a DNR (do not resuscitate). The findings included:	F 280	1. Resident # 22 experienced no ill effects as result of the care plan not being updated and subsequently has discharged from the facility. 2. Any resident has the potential to be affected if the comprehensive care plan is not updated when the patient/resident experiences a change in status/orders. An audit will be completed of any	

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F 280	Continued From page 21 Resident #22 was admitted to the facility on 2/17/17 and was discharged to the hospital on 3/21/17. Her diagnoses included, but not limited to, anoxic brain injury due to Tylenol overdose; aspiration pneumonia, pericardial effusion, dysphagia with feeding tube, severe malnutrition, pressure wounds, catatonic disorder, anemia, deep venous thrombosis (DT) of right upper extremity, contractors of bilateral hands, ankles, and feet with chronic pain. Resident #22 no longer resided at the facility therefore a closed record review was conducted. Resident #22's Admission Minimum Data Set assessment with an Assessment Reference Date of 2/24/17 coded Resident #22 severe cognitive impairment; was dependent on staff for locomotion on and off the unit, eating, toileting, hygiene and bathing; required extensive assistance from 2 staff for bed mobility, transfers, and dressing; had range on motion impairment on bilateral upper and lower extremities; was always incontinent of bowel and bladder. On 7/26/17 at 8:30 a.m. Resident #22's electronic clinical record was reviewed. The review revealed physician orders which included code status dated 2/17/17 as "Full Code" and an order dated 2/22/17 for "DNR." Resident #22's care plan with a "date initiated" and "created on" as 2/24/17 listed the "Focus" as "Resident has a Full Code status." Under "Goal" a revision date of 3/6/2017 was listed however the code status was not updated to reflect the DNR order from 2/22/17. On 7/26/17 at 2:40 p.m. the Administrator and Director of Nursing (Employee-B) were informed	F 280	changes of condition, new orders or changes in status to ensure the care plan was updated appropriately with corrective action taken as needed from 8/7/17. 3. The interdisciplinary team members responsible for updating care plans will be re-educated regarding the requirement of updating care plans with episodic changes/ changes in orders/ status to ensure the care plan accurately reflects care of the patient/resident. 4. The DON/designee will audit care plans daily 5 x per week for 4 weeks, then weekly x 8 weeks to ensure episodic changes and changes in status/orders are made in the comprehensive care plan as indicated. The results of the audits will be forwarded to the QAPI committee for review. 5. AOC: 9/5/17	

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F 280	Continued From page 22 of the finding. The surveyor asked for clarification. On 7/27/17 at 8:20 a.m. when Employee-B was asked about the code status on the care plan, Employee-B stated the "Care plan needed to be revised, she was a DNR." No further information was provided by the facility staff.	F 280		
F 281 SS=E	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 by: Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to follow the professional standards of practice for four Residents (Res. #12, 21, 22, and #11) in a survey sample of 31 Residents. 1. For Resident #12, the facility staff failed to follow physician's orders by attempting to administer synthroid medication by mouth when the Resident was to have nothing by mouth, and failed to administer enteral feedings and water as prescribed. The physician was not notified, of these omissions. 2. For Resident #21, the facility staff failed to follow physician's orders by omitting the	F 281	1. Resident #12's physician was notified of the need for clarification of route of medication, omission of medication, omission of enteral feeding and hydration on 7/26/17 with new orders initiated. Resident # 21 was discharged from the facility on 1/23/17. Resident # 22 was discharged from the facility on 3/21/17. Resident #11's duplicative orders were discontinued on 7/27/17. 2. Any resident receiving medications within the facility has the potential to be affected if medications are reviewed, clarified, and administered per physician□s orders and/or the physician is not notified when medications are not	9/5/17

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F 281	Continued From page 23 administration of atorvastatin, prednisone, Oxygen, and nebulizer treatments. The physician was not notified, of these omissions. 3. For Resident #22, the facility staff failed to clarify and have discontinued one of two tube feeding orders that were on the Medication Administration Record (MAR). 4. The facility staff failed to alert the physician regarding multiple orders for Lorazapam on the physician order sheet for Resident #11. The findings included: 1. For Resident #12, the facility staff failed to follow physician's orders by attempting to administer synthroid medication by mouth when the Resident was to have nothing by mouth, and failed to administer enteral feedings and water as prescribed. The physician was not notified, of these omissions. Resident #12 was admitted to the facility on 7-19-17. Diagnoses for Resident #12 included but were not limited to; Gastrostomy tube for feeding and medication administration, stroke, hypertension, atrial fibrillation, hypothyroidism, high cholesterol, osteoporosis, prosthetic heart valve, and transient ischemic attacks. Resident #12's most recent Minimum Data Set (MDS), was not yet completed, as the Resident had not been in the facility a full week upon entrance to the survey. Review of nursing notes, observation, and the initial care plan indicated that the Resident required extensive assistance for all Activities of Daily Living care.	F 281	administered per order. An audit of new orders beginning on 8/7/17 will be completed to ascertain if clarification is needed and an audit of the EMAR and ETAR will be completed beginning on 8/7/17 to ensure omissions have been communicated to the physician with corrective action taken as needed. 3. Licensed nurses will be re-educated to ensure that any order given by the physician or mid-level provider is reviewed for clarity and the process for notification of orders not followed. 4. The DON/designee will audit new orders and progress notes daily 5 x/ week for 4 weeks, then weekly x 8 weeks for medications requiring clarification and physician notification of any omission of ordered medications. Results will be forwarded to the QAPI committee for review. 5. AOC: 9/5/17	

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F 281	Continued From page 24 On 7-26-17 beginning at 8:30 a.m., surveyor observations were conducted, by 2 surveyors. From 8:30 a.m., until 11:00 a.m. no tube feeding was infused. The Resident was laying in bed clothed. At 11:00 a.m. the Resident's spouse came in to take the Resident out for a neurological appointment. The mechanical pump which instilled the feeding was at bedside turned off, and when turned on, showed no history of the last infusion. A review of Resident #12's clinical record was conducted during the survey. The review showed five current tube feeding physician's orders dated 7-19-17. The orders read that Resident #12 was to have the following: 1. "Two times a day Isosource HN @ 75 ml/hr (milliliters per hour) x 16 hours (1200 ml) up at 1800 (6:00 p.m.) down at 1000 (10:00 a.m.)." 2. "Continuous feeding: check residual every 8 hours. If 100 ml (milliliters) or over, hold feeding for one hour and recheck: If residual 100 ml or over, notify the physician. Document amount of residual every shift." 3. "Document Intake every shift". 4. "Two times a day 40 ml H2O (water) every hour x 16 hours (640 ml) with enteral feeding." up at 6:00 p.m., and down at 10:00 a.m." 5. NPO (nothing by mouth) A review of Resident #12's Medication and Treatment Administration Records (MAR/TAR) for July 2017, revealed that Resident #12 did not have a residual check for the continuous feeding	F 281		

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F 281	Continued From page 25 on 7-24-17 in the morning, nor that evening. The nurse placed an "X" in the area designated for residual amount in the morning, and did not sign the MAR at all for the evening. There were no nursing notes to explain the omissions. On the second order, for intake documentation, there was no documentation of any intake on 7-24-17 on evening, or night shifts. On 7-26-17 there was no documentation for the day shift, of the feeding amount even though the feeding had been discontinued prior to 8:30 a.m.. On 7-26-17 the feeding order was signed at 10:00 a.m., as if the full administration of feeding had occurred, however, surveyors observed no feeding infusing from 8:30 a.m. through 10:00 A.M., a loss of 112.5 ml of feeding, and 60 ml of water. The MAR further revealed that on 7-20-17 Levothyroxine for hypothyroidism was administered in the morning via the gastrostomy tube, and Leflunomide for Rheumatoid Arthritis was not administered, nor noted in the nurse notes. The MAR states "other/see nurse notes" for both medications. The nursing notes stated "refused to open mouth." The Resident was NPO. On 7-26-17 at approximately 4:00 p.m., an interview was conducted with the Director of Nursing (DON), and Administrator, and they were made aware of the absence of feeding and hydration at the above observations. The DON and Administrator stated they would look into the issue. The facility policy on medication administration stated "give medications as ordered." On 7-27-16, the DON entered with the unit manager RN (Registered Nurse) C, who stated	F 281		

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F 281	Continued From page 26 the nurse had just taken the feeding down the previous day at 9:00 a.m. because they were allowed a window of 1 hour before and 1 hour after the stated order time to administer medications. It was explained at that time that this "allowance" in the standards was for medication administration which had no effect on potency of a drug, however, that is not true of calorie intake, and water intake. Omissions of over an hour of tube feeding, and water occurred as the feeding had not been infusing at 8:30 a.m. The reason for the 16 hour order, was to meet the required caloric, and hydration needs of this Resident. The Director of Nursing gave "Lippincott" as the standard for nursing practice in the facility. "Fundamentals of Nursing, by Lippincott", provides guidance for nursing standards. The reference stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients." The facility administration was informed of the findings during the end of day debriefing on 7-26-17 at 5:00 p.m., and 7-27-17 at 11:00 a.m. No further evidence was able to be provided by the facility. 2. For Resident #21, the facility staff failed to follow physician's orders by omitting the administration of atorvastatin, prednisone, Oxygen, and nebulizer treatments. The physician was not notified, of these omissions. Resident #21 was admitted to the facility on	F 281		

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F 281	Continued From page 27 12-17-16. Diagnoses for Resident #21 included but were not limited to; congestive obstructive pulmonary disease (COPD), Oxygen dependence, sleep apnea, Pleural effusion, congestive heart failure, obesity, Gastroesophageal refux disease, hypertension, diabetes, depression, and chronic kidney disease. Resident #21's most recent Minimum Data Set (MDS), was an admission assessment with an ARD (assessment reference date) of 12-24-16. The resident was coded as having no cognitve impairment, and required extensive to total assistance on staff for activities of daily living such as dressing, and bathing. The Resident was discharged home on 1-23-17 (37 day stay), and so a closed record review was conducted. A review of Resident #21's clinical record was conducted during the survey. The review showed four physician's orders that were not administered as ordered by the physician. The orders read that Resident #21 was to have the following: 1. "Atorvastatin tab 20 mg (milligrams) give 0.5 tablet by mouth at bedtime for HLD (high cholesterol) give total of 10 mg." To be administered at 9:00 p.m. 2. "Prednisone 5 mg give 2 tablets by mouth one time per day for COPD for 3 days." To be administered at 9:00 a.m. 3. "O2 (oxygen) at 2-3 liters per minute via nasal cannula, continuously every shift for shortness of breath". Which the Resident used at home and was admitted to the hospital, and nursing facility with due to acute respiratory distress and hypoxia.	F 281		

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F 281	Continued From page 28 4. "Ipratropium-Albuterol (hand held nebulizer) solution 0.5-2.5 (3) mg per 3 ml. Give 3 ml inhale orally every 4 hours around the clock". A review of Resident #21's Medication and Treatment Administration Records (MAR/TAR) for December 2016, and January 2017, revealed that Resident #21 did not receive Atorvastatin on 12-18-16, prednisone on 12-21-16, and 12-22-16, Oxygen 12-17-16, 12-18-16, and part of 12-19-16, and Ipratropium-Albuterol (hand held nebulizer) 1-1-17, and 1-3-17 at 1:00 a.m. both times, nusing notes stated "asleep and comfortable", and was not attempted. No notes describe why these medications were omitted, and no indication was documented that the doctor was ever made aware of the omissions. On 7-26-17 at approximately 4:00 p.m., an interview was conducted with the Director of Nursing (DON), and Administrator, and they were made aware of the absence of the medications and oxygen. The DON and Administrator stated they would look into the issue. The facility policy on medication administration stated "give medications as ordered." The Director of Nursing gave "Lippincott" as the standard for nursing practice in the facility. "Fundamentals of Nursing, by Lippincott", provides guidance for nursing standards. The reference stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients." The facility administration was informed of the findings during the end of day debriefing on	F 281		

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F 281	Continued From page 29 7-26-17 at 5:00 p.m., and 7-27-17 at 11:00 a.m. No further evidence was able to be provided by the facility.	F 281		
	3. For Resident #22, the facility staff failed to clarify and have discontinued one of two tube feeding orders that were on the Medication Administration Record (MAR). Resident #22 was admitted to the facility on 2/17/17 and was discharged to the hospital on 3/21/17. Her diagnoses included, but not limited to, anoxic brain injury due to Tylenol overdose; aspiration pneumonia, pericardial effusion, dysphagia with feeding tube, severe malnutrition, pressure wounds, catatonic disorder, anemia, deep venous thrombosis (DT) of right upper extremity, contractors of bilateral hands, ankles, and feet with chronic pain. Resident #22's Admission Minimum Data Set assessment with an Assessment Reference Date of 2/24/17 coded Resident #22 severe cognitive impairment; was dependent on staff for locomotion on and off the unit, eating, toileting, hygiene and bathing; required extensive assistance from 2 staff for bed mobility, transfers, and dressing; had range of motion impairment on bilateral upper and lower extremities; was always incontinent of bowel and bladder. On 7/26/17 at 8:30 a.m. Resident #22's electronic clinical record was reviewed. The review revealed a physician's order dated 2/18/17 which read "Enteral Feed Order every shift Continue			

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F 281	Continued From page 30 Isosource HN 1.2 AT 35ml/hr (milliliters per hour). Flush with free water flushes 75ml Q 4hrs (every 4 hours) (until dietitian evaluate and d/c (discontinues order) and an order dated 2/18/17 which read "Enteral Feed Order one time a day Peptamen 1.5 @ 60ml/hr x 20 hours (1200ml) up at 1400 (2 p.m.) down at 1000 (10:00 a.m.). The dietitian had evaluated Resident #22 on 2/18/17 at 3:11 p.m. and changed the tube feeding order from Isosource to Peptamen. The MAR had both orders listed on it with nurses initials as administered from 2/18/17 through 2/23/17 when the order for Isosource HN was removed. On 7/26/17 at 2:40 p.m. the Administrator and Director of Nursing were informed of the two different tube feeding orders being on the MAR and signed as administered. On 7/27/17 at 8:20 a.m. an interview was conducted with the Registered Dietitian (Employee-D) and the Director of Nursing (Employee-B). The tube feeding orders was discussed. Employee-D stated "On Saturday (2/18/17) I actually brought the bag (Peptamen) to the unit and saw it hung." She stated "I know both feedings were not hung at the same time." Employee-B stated there was "No way both feedings could be administered." When asked what she would expect happen with the orders, Employee-B stated she "Would expect nurse to discontinue the order." Guidance given from Potter and Perry, Fundamentals of Nursing, Eighth Edition, page 305 read: Nurses follow health care providers' orders unless they believe the orders are in error or harm patients. Therefore you need to assess	F 281		

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F 281	Continued From page 31 all orders; if you find one to be erroneous or harmful, further clarification from the health care provider is necessary. Page 584 read: To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to these rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation When asked what professional reference source the facility uses, Employee-B stated Lippincott. No further information was provided by the facility staff. Complaint deficiency. 4. The facility staff failed to alert the physician regarding multiple orders for Lorazapam on the Physician Order Sheet for Resident #11. Resident #11, a 52 year old female, was admitted to the facility on 12/13/2016 and readmitted on 2/17/2017. Resident #11's diagnoses included CVA (Cerebral Vascular Accident-stroke), epilepsy, anxiety, lupus, anemia, and hypertension. Resident #11 receives nutrition via a feeding tube implanted in the stomach. Resident #11's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date)	F 281		

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F 281	Continued From page 32 of 6/27/2017 was coded as a quarterly assessment. Resident #11 was coded as having severe cognitive impairment by a staff assessment. She was coded as being totally dependent on 2-3 persons for her activities of daily living, and as being always incontinent of bowel and bladder. On 7/25/2017 at 11:00 AM a review of Resident #11's clinical record was conducted and it revealed the latest POS (Physician Order Sheet) dated 6/27/2017. This POS contained the following duplicate orders for Lorazapam, a sedative: 5/5/2017-"Lorazapam tablet 0.5 mg (milligram) give 0.25 mg via g-tube every 6 hours as needed for anxiety" 5/7/2017-"Lorazapam tablet 0.5 mg give 0.5 tablet via g-tube every 4 hours as needed for agitation" 5/4/2017-"Lorazapam tablet 0.5 mg give one tablet via g-tube every 4 hours as needed for agitation" 3/2/2017-"Lorazapam tablet 0.5 mg give one tablet via g-tube every 4 hours as needed for increased agitation" The MAR (Medication Administration Record) for May, June, and July 2017 was examined. All four Lorazapam orders were on these Mar's, but no Lorazapam was administered during that time per these orders. On 7/26/2017 at 10:10 AM an interview was conducted with Employee B, Director of Nursing,	F 281		

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F 281	Continued From page 33 who stated that there should not be four separate orders for Lorazapam and did not know how these four orders were on the POS and no one brought it to the attention of the physician. Administration was informed of the findings on 7/27/2017 at 11:00 AM.	F 281		
F 309 SS=D	Complaint deficiency 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,	F 309		9/5/17

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F 309	Continued From page 34 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record review, and in the course of a complaint investigation, the facility staff failed, for one Resident (Resident #19) in a survey sample of 31 residents, to maintain the highest practicable well being. Resident #19 did not receive her physician ordered pain medication as ordered. The findings included: Resident #19 was admitted to the facility 2/20/17. Diagnoses included asthma, recent right knee replacement and sleep apnea. The resident arrived at the facility on 2/20/17 at 8:30 PM. The resident left the facility on 2/21/17 and was re-admitted to the hospital. A comprehensive MDS (minimum data set) was not completed for this resident, but a Medicare five day assessment with an ARD (assessment reference date) of 2/21/17 coded the resident as having no short or long term memory loss. The resident required extensive to total assistance of one staff member for bed mobility and transferring.	F 309	1. It is duly noted that Resident #19 did not receive medication ordered by the physician. Resident # 19 was discharged on 2/21/17. 2. Any resident receiving medications within the facility has the potential to be affected if prescribed medications are not administered according to physician□s orders. An audit of the EMAR and new orders written will be completed to ensure medications were both available and administered as ordered by the physician beginning 8/7/17. 3. Licensed nurses will be re-educated regarding pharmacy procedures for procurement of medications to ensure they are available for administration or if unable to obtain, the physician has been notified so alternative orders can be given. 4. The DON/designee will audit all new medication orders and EMAR□s daily 5 x/week x 4 weeks, then weekly x 8 weeks to ensure medications are available for	

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F 309	Continued From page 35 Review of the resident's MAR (medication administration record) for February, 2017, included the following medication orders for pain: Gabapentin (nerve pain) 300 mg (milligrams) twice daily. The 2/20/17 evening dose was not documented as given. Norco tablet 10/325 mg every 4 hours as needed for pain. Norco (Percocet) is a opoid schedule II narcotic used for mild to moderately severe pain. There was no documentation that this medication was given during the resident's stay. The nurses notes dated 2/20/17 at 10:55 PM read as followed: "She stated pain on a scale of 0 to 10 was 5. Prn (as needed) pain med Tylenol 2 tabs given." There was no follow up documented as to the effectiveness of the Tylenol. The next nurses note was dated 2/212/17 at 7:21 AM, which read: "Resident is alert and oriented x 3 new admit day 1/3 no complaints noted. On c-pap no signs or symptoms of respiratory distress, surgical wound to right leg with dressing intact, visible bleeding noted on dressing no signs or symptoms of infection noted." The last nurses note dated 2/21/17 at 10:24 AM noted, "Resident alert and oriented x 3, new admit day 1/3, complain (sic) of right knee on a pain scale of 4/10. Prn Norco and Ativan (antianxiety) at 9:20 AM.... right knee surgical site noted bleeding with some redness, area is warm to touch, call paced to MD... Patient insist she go to the hospital...transferred at 10:30 AM. Vital signs: Temperature 99.0, heart rate 81, respirations 20 and blood pressure 106/51, O 2 sat (oxygen in blood) 98% on room air."	F 309	administration and given accordingly. Results will be forwarded to the QAPI committee for review. 5. AOC: 9/5/17	

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F 309	Continued From page 36 Review of the initial nursing assessment dated 2/21/17 revealed, "the resident reported pain frequently in the last 5 days, which made it harder to sleep." It was also noted on the assessment the resident had been taking Percocet. Review of the Emergency Room records and the assessment and plan dated 2/21/17 by the nurse practitioner revealed "Intractable pain, poor pain control at the SNF (skilled nursing facility)." The History and Physical documented on 2/21/17 contained the following: "Patient did not have the expected care and follow up in the SNF that she was in. Patient states she did not get any pain medication, her knee was accidentally bumped, and that started bleeding, making the pain worse and per patient did not receive any pain meds for that either. Patient had to be brought back to the hospital for pain management." On 7/26/17 at 10:00 AM, a phone interview was conducted with LPN (licensed practical nurse A). LPN (A) was asked about why the resident did not receive her physician ordered Percocet during the night. LPN (A) stated, "I was told the medication would be delivered in the morning as we did not have the medication available." She went on to state the resident was given Tylenol at 8:30 PM and she slept until 5:30 AM or 6:00 AM. The pain level documented at this time was "5" on a scale of 0-10. There was no documentation of the effectiveness of the Tylenol. She continued that the resident did not have any complaints and did not call for anything. LPN A then stated, "I handed it over to the day nurse to give right now." The Percocet and Ativan were given to the resident on 2/21/17 at 9:20 AM.	F 309		

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HERNDON, VA 20171

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 37 On 7/26/17 at 10:30 AM, the DON (director of nursing) was asked for the list of stat (emergency) medications, including narcotics, available for emergency use. The list did contain the physician ordered Percocet. On 7/27/17 at 11:00 AM, the DON was asked what the nurse should have done to ensure the resident received her pain medication. She stated, "She should have called the physician to let him know it was unavailable so he could order something else." The above allegation is substantiated with a deficiency as the resident did not receive her physician ordered pain medication until the following morning. In addition, the nurse failed to document the effectiveness of the Tylenol that was given.	F 309		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited	F 323		9/5/17

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F 323	Continued From page 38 to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to provide a safe environment on 1 of 4 units. A medication cart was left unlocked and unattended on Unit 1. The findings included: A medication pour and pass observation was conducted on 7/25/17 at 8:10 a.m. with Registered Nurse A (RN A). At the start of the observation, RN A stated that she needed to re-stock the applesauce on her cart. When RN A left her cart, she left it unlocked. RN A was not within sight of the cart. The back of the cart was against the wall, the front of the cart, to include the medication drawers, faced the hallway. There were no residents near the cart. While RN A was away from the cart, the Education Coordinator walked up to the cart, pressed in the lock so that the cart was now locked. This surveyor stated to the Education Coordinator that RN A needed to know that her cart was left unlocked. Once RN A came back to	F 323	1. It is duly noted that a medication cart was left unlocked and unattended by the primary nurse resulting in another nurse who was there needing to secure it. The primary nurse reeducated to ensure medication cart is secured before walking away from it on 7/25/2017. 2. Any resident in the center has the potential to be affected if medication carts are unattended and not secured. Medication carts were checked throughout the day to ensure that there was no further incidence noted. 3. Licensed nurses will be re-educated to ensure the medication cart is not left unattended and unlocked. 4. The DON/designee will randomly audit the nursing carts during med pass times daily 5 times per week for 2 weeks on all shifts, weekly for 2 weeks and then monthly for 2 months. Results will be forwarded to the QAPI committee for review.	

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F 323	Continued From page 39 her cart with the applesauce, the Education Coordinator approached RN A and reviewed that the medication cart needed to be locked. The issue was reviewed with the Administrator and Director of Nursing on 7/26/17 at 12:15 p.m. The Administrator stated that she was aware that the cart had been left unlocked.	F 323	5. AOC: 9/5/17	
F 367 SS=D	THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN CFR(s): 483.60(e)(1)(2) (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to provide a therapeutic diet as per physician's orders for two Residents (Resident #12, and #22) in a survey sample of 31 Residents. 1. For Resident #12, the Resident's enteral feeding was not infusing as per physician's therapeutic diet orders on 7-26-17. 2. For Resident #22, the facility staff failed to order and initiate tube feeding in a timely manner.	F 367	1. Resident #12 experienced no ill effects as a result of not following the physician's orders for tube feeding. The physician was notified of this finding on 7/26/2017. Resident # 22 was discharged from the facility on 3/21/17. 2. Any resident requiring enteral feedings has the potential to be affected if the enteral feedings are not provided per the physicians order. An audit of current patient/resident□s with enteral feeding orders was done to ensure the orders are appropriate and	9/5/17

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F 367	Continued From page 40 The findings included: 1. For Resident #12, the Resident's enteral feeding was not infusing as per physician's therapeutic diet orders on 7-26-17. Resident #12 was admitted to the facility on 7-19-17. Diagnoses for Resident #12 included but were not limited to; Gastrostomy tube for feeding and medication administration, stroke, hypertension, atrial fibrillation, hypothyroidism, high cholesterol, osteoporosis, prosthetic heart valve, and transient ischemic attacks. Resident #12's most recent Minimum Data Set (MDS), was not yet completed, as the Resident had not been in the facility a full week upon entrance to the survey. Review of nursing notes, observation, and the initial care plan indicated that the Resident required extensive assistance for all Activities of Daily Living care. On 7-26-17 beginning at 8:30 a.m., surveyor observations were conducted, by 2 surveyors. From 8:30 a.m., until 11:00 a.m. no tube feeding was infused. The Resident was laying in bed clothed. At 11:00 a.m. the Resident's spouse came in to take the Resident out for a neurological appointment. The mechanical pump which instilled the feeding was at bedside turned off, and when turned on, showed no history of the last infusion. A review of Resident #12's clinical record was conducted during the survey. The review showed five current tube feeding physician's orders dated 7-19-17. The orders read that Resident #12 was to have the following;	F 367	accurate, the tube feedings are being administered per order and the documentation supports said orders with corrective actions taken as needed. 3. Licensed nurses and the registered dietician will be re-educated regarding orders necessary for Residents requiring enteral feeding; including monitoring for residual, maintaining NPO status as appropriate and documentation of pertinent information in the EHR. 4. The DON/designee will audit enteral feedings for orders, hang time and documentation daily 5 days per week x 4 weeks, weekly x 4 weeks, then monthly for 1 month to ensure therapeutic diet is being followed as per physician□s orders. Results will be forwarded to the QAPI committee for review. 5. AOC: 9/5/17	

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F 367	Continued From page 41 1. "Two times a day Isosource HN @ 75 ml/hr (milliliters per hour) x 16 hours (1200 ml) up at 1800 (6:00 p.m.) down at 1000 (10:00 a.m.)." 2. "Continuous feeding: check residual every 8 hours. If 100 ml (milliliters) or over, hold feeding for one hour and recheck: If residual 100 ml or over, notify the physician. Document amount of residual every shift." 3. "Document Intake every shift". 4. "Two times a day 40 ml H2O (water) every hour x 16 hours (640 ml) with enteral feeding." up at 6:00 p.m., and down at 10:00 a.m." 5. NPO (nothing by mouth) A review of Resident #12's Medication and Treatment Administration Records (MAR/TAR) for July 2017, revealed that Resident #12 did not have a residual check for the continuous feeding on 7-24-17 in the morning, nor that evening. The nurse placed an "X" in the area designated for residual amount in the morning, and did not sign the MAR at all for the evening. There were no nursing notes to explain the omissions. On the second order, for intake documentation, there was no documentation of any intake on 7-24-17 on evening, or night shifts. On 7-26-17 there was no documentation for the day shift, of the feeding amount even though the feeding had been discontinued prior to 8:30 a.m.. On 7-26-17 the feeding order was signed at 10:00 a.m., as if the full administration of feeding had occurred, however, surveyors observed no feeding infusing from 8:30 a.m. through 10:00 a.m., a loss of 112.5 ml of feeding, and 60 ml of water.	F 367		

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F 367	Continued From page 42 The MAR further revealed that on 7-20-17 Levothyroxine for hypothyroidism was administered in the morning via the gastrostomy tube, and Leflunomide for Rheumatoid Arthritis was not administered, nor noted in the nurse notes. The MAR states "other/see nurse notes" for both medications. The nursing notes stated "refused to open mouth." The Resident was NPO. On 7-26-17 at approximately 4:00 p.m., an interview was conducted with the Director of Nursing (DON), and Administrator, and they were made aware of the absence of feeding and hydration at the above observations. The DON and Administrator stated they would look into the issue. The facility policy on medication administration stated "give medications as ordered." On 7-27-16, the DON entered with the unit manager RN (Registered Nurse) C, who stated the nurse had just taken the feeding down the previous day at 9:00 a.m. because they were allowed a window of 1 hour before and 1 hour after the stated order time to administer medications. It was explained at that time that this "allowance" in the standards was for medication administration which had no effect on potency of a drug, however, that is not true of calorie intake, and water intake. Omissions of over an hour of tube feeding, and water occurred as the feeding had not been infusing at 8:30 a.m. The reason for the 16 hour order, was to meet the required caloric, and hydration needs of this Resident. The Director of Nursing gave "Lippincott" as the standard for nursing practice in the facility.	F 367		

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F 367	Continued From page 43 "Fundamentals of Nursing, by Lippincott", provides guidance for nursing standards. The reference stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients." The facility administration was informed of the findings during the end of day debriefing on 7-26-17 at 5:00 p.m., and 7-27-17 at 11:00 a.m. No further evidence was able to be provided by the facility. 2. For Resident #22, the facility staff failed to order and initiate tube feeding in a timely manner. Resident #22 was admitted to the facility on 2/17/17 and was discharged to the hospital on 3/21/17. Her diagnoses included, but not limited to, anoxic brain injury due to Tylenol overdose; aspiration pneumonia, pericardial effusion, dysphagia with feeding tube, severe malnutrition, pressure wounds, catatonic disorder, anemia, deep venous thrombosis (DT) of right upper extremity, contractors of bilateral hands, ankles, and feet with chronic pain. Resident #22's Admission Minimum Data Set assessment with an Assessment Reference Date of 2/24/17 coded Resident #22 severe cognitive impairment; was dependent on staff for locomotion on and off the unit, eating, toileting, hygiene and bathing; required extensive assistance from 2 staff for bed mobility, transfers, and dressing; had range on motion impairment on bilateral upper and lower extremities; was	F 367		

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F 367	Continued From page 44 always incontinent of bowel and bladder. On 7/26/17 at 8:30 a.m. Resident #22's electronic clinical record was reviewed. The review included the following: Tube feeding: The hospital discharge instructions included the following: "Diet Instructions for after discharge Continuous Tube Feedings: TwoCal HN (or equivalent 2Kcal/ml formula) at 35ml/hr with 1 packet of Prosource per day, 2 packets of Juven per day, 2 packets of Nutrisource fiber BID (2 times daily), additional free water flushes 75 ml Q4hrs (every 4 hours) Can shorten duration of feeds to 16 hrs by running TwoCal HN at 55ml/hr x16hrs with 1 packet of Prosource per day, 2 packets of Juven per day, 2 packets of Nutrisource fiber BID, additional free water flushes 75ml Q4hrs." Review of facility documentation upon admission revealed the following documentation and orders: A "PHYSICIAN NARRATIVE NOTE" was dated and timed for 2/17/2017 at 8:19 p.m. included: "...59 year old with PMH (past medical history) of anoxic brain injury after tylenol overdose in 2006, nonverbal, with contractures of all extremities. Admitted to hospital, had extended stay, diagnosed with recurrent HCAP/aspiration PNA (health care acquired pneumonia), fungal bacteremia, RUE DVT..., pericardial effusion...Here for total care, PT/OT (physical and occupational therapy)...Lab results/Radiology reports-extensive hospital results reviewed... Assessment & Plan-...7. dysphagia-enteral feeds, SLP (speech-language pathologist) and RD (registered dietitian) following 8. severe	F 367		

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F 367	Continued From page 45 malnutrition-RD following..." The first nursing progress note was dated and timed for 2/18/17 at 1:57 AM and included: "...head to toe nursing assessment noted, no s/s (signs/symptoms) of discomfort noted patient in nonverbal...peg tube is intact...open wound right ankle, MD made aware, bed in lowers position...Feeding is in progress." The time of Resident #22's arrival to the facility was not included in the documentation. On 7/26/17 at 12:05 p.m. the Director of Nursing (Employee-B) was asked what time the resident arrived to the facility on 2/17/17. She presented a "Wandering Risk Assessment" form dated and timed for 2/17/17 at 17:53 (5:53 p.m.). Employee-B stated Resident #22 was admitted "around 5 o'clock." At 1:40 p.m. the Administrator presented an internal facility notification email dated and timed for 2/17/17 at 3:37 p.m. which read "Pt has arrived." The resident's name was included on the subject line of the email. The first order for tube feeding was documented as: "Order Date: 02/18/2017 00:20 (12:20 a.m.)" "Communication Method: Phone" "Order Summary: Enteral Feed Order every shift Continue Isosource HN 1.2 AT 35 ml/hr. Flush with free water flushes 75ml Q4hrs (until dietitian evaluate and d/c order)" The order was "Confirmed By: (Name) RN Supervisor." The medication administration record for February 2017 listed the order as written above, however it was first documented as administered on 2/18/17 on the "day" shift which was 7 a.m. to 3 p.m. From email notification to the time the tube feeding order was received was	F 367		

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F 367	Continued From page 46 approximately 8 hours. On 7/26/17 at 3:15 p.m. an interview was conducted with Employee-B. She presented the physician's order from 2/18/17 at 12:20 a.m. She stated "The admission note states the tube feed was in progress." She also stated the doctor was in the day Resident #22 was admitted. Reviewed with the Director of Nursing that the doctor's note was dated 2/17/17 at 8:19 p.m. and it did not include documentation that the tube feeding was running. Employee-B stated the nurse wrote the order late but the feeding was in progress upon admission. On 7/27/17 at 8:20 a.m. an interview was conducted with the Registered Dietitian (Employee-D). Documentation and discussion revealed Employee-D evaluated Resident #22 on 2/18/17 at 3:11 p.m. and changed the tube feeding order to an easily digestible formula called Peptamen. She stated "when the resident got to me she was severely malnourished." During the course of her stay Resident #22 had an approximate weight gain of 12 pounds. On 7/27/17 at 9:10 a.m. an interview was conducted with the Central Supply staff (Employee-L). When asked about the process when a new admit arrives with tube feedings she explained: She remembered she brought Isorsource 1.5 ready to hang and pump and pole to the unit around 4 p.m. Employee-L stated she would be informed by nursing what to bring to the unit. She stated she does not keep documentation on exact times or items brought to unit. On 7/27/17 at 10:00 a.m., the Administrator and	F 367		

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F 367	Continued From page 47 Director of Nursing were informed that the concern remains of tube feeding not ordered until midnight and requested to speak with the RN Supervisor. The Director of Nursing provided his phone number to surveyor and stated he worked another job so he might not answer. On 7/27/17 at 10:04 a.m. a message was left on RN-B's voice mail to return surveyor's call. No return call was received. On 7/27/17 at 10:25 a.m. the Administrator and Director of Nursing were informed the concern of the delay in obtaining and initiating the tube feeding remained. No further information was provided by the facility staff.	F 367		
F 371 SS=E	Complaint Deficiency. 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 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 371		9/5/17

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F 371	Continued From page 48 (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 documentation review, the facility staff failed to serve food according to professional standards. Dietary staff failed to use proper hand washing technique. The findings included: An initial tour of the main kitchen took place on 7/24/17 at 2:02 p.m. Employee H was working at the dish machine. She proceeded to the hand washing sink in the dish room and washed her hands. Employee H did not use a paper towel to turn off the faucet after washing her hands. She used her bare hands. At 2:30 p.m., while still on tour in the main kitchen, Employee I was observed to wash her hands. She did not use a paper towel to turn off the faucet after washing her hands. She used her bare hands. On 7/24/17 at 5:12 p.m., dinner service was observed with Employee J in the Unit 4 kitchen. Employee J washed her hands. She did not use a paper towel to turn off the faucet after washing her hands. Employee J washed her hands again at 5:16 p.m. She washed for about 10 seconds	F 371	1. It is noted that the dietary staff did not use proper hand washing technique while being observed. Dietary staff were reeducated on proper hand washing techniques on 7/25/17. 2. Any resident has the potential to be affected if dietary staff does not use proper handwashing technique. Staff were reminded at the time, as well as immediately after the observations were made, to use proper handwashing technique. 3. The dietary staff will be re-educated on proper handwashing technique. 4. The Administrator/designee will observe each food preparation area during at least 2 meals 5 times per week for proper handwashing technique for a total of 12 weeks. Results will be forwarded to the QAPI committee for review. 5. AOC: 9/5/17	

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F 371	Continued From page 49 and did not use a paper towel to turn off the faucet after washing her hands. She washed her hands again at 5:27 p.m. and did not use a paper towel to turn off the faucet after washing her hands. The facility policy "Procedure for Hand washing" was reviewed. The policy read "4. Dry hands well. When finished, turn off faucet with a clean paper towel. Discard the towel in an appropriate trash container." On 7/26/17 at approximately 10:00 a.m., the issue with the hand washing was reviewed with the Dietary Director. It was reviewed that three staff were observed to shut off the faucet with their bare hands instead of using a paper towel. The Dietary Director stated that he had just completed hand washing training with the staff on 7/25/17. He stated that the policy "Procedure for Hand washing" (referenced above) was reviewed with the dietary staff during the training. The hand washing issue was also reviewed with the Administrator and Director of Nursing on 7/26/17 at 12:15 p.m.	F 371		
F 386 SS=D	PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS CFR(s): 483.30(b)(1)-(3) (b) Physician Visits The physician must-- (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; (2) Write, sign, and date progress notes at each	F 386		9/5/17

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F 386	Continued From page 50 visit; and (3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review the physician failed to accurately review Resident #11's medications. 1. For Resident #11, the physician approved duplicate orders for Lorazapam. Findings included: Resident #11, a 52 year old female, was admitted to the facility on 12/13/2016 and readmitted on 2/17/2017. Resident #11's diagnoses included CVA (Cerebral Vascular Accident-stroke), epilepsy, anxiety, lupus, anemia, and hypertension. Resident #11 receives nutrition via a feeding tube implanted in the stomach. Resident #11's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/27/2017 was coded as a quarterly assessment. Resident #11 was coded as having severe cognitive impairment by a staff assessment. She was coded as being totally dependent on 2-3 persons for her activities of daily living, and as being always incontinent of bowel and bladder. On 7/25/2017 at 11:00 AM a review of Resident	F 386	1. Resident # 11 experienced no ill effects as a result of the duplicative order for as needed lorazepam as it was not ever administered per those orders. Resident # 11□s orders were reconciled on 7/27/17. 2. Any resident receiving medications within the facility has the potential to be affected by duplicative orders not reconciled by the physician at the time of visit. An audit will be done of current resident□s last visit and signing of orders to ensure that medications are not duplicative with corrective action taken as needed. 3. The physicians and mid-level providers making required visits will be re-educated regarding the need to review the total program of care, including medications. 4. The DON/designee will audit physicians required visits and accompanying physicians order sheets to ensure medications have been reconciled as that no duplicative orders exist and orders accurately reflect the needs of the patient weekly for 12 weeks. The results of the audits will be forwarded to the QAPI	

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F 386	Continued From page 51 #11's clinical record was conducted and it revealed the latest POS (Physician Order Sheet) dated 6/27/2017. There was a physician signature on this POS dated 6/29/2017. This POS contained the following duplicate orders for Lorazapam, a sedative: 5/5/2017-"Lorazapam tablet 0.5 mg (milligram) give 0.25 mg via g-tube every 6 hours as needed for anxiety" 5/7/2017-"Lorazapam tablet 0.5 mg give 0.5 tablet via g-tube every 4 hours as needed for agitation" 5/4/2017-"Lorazapam tablet 0.5 mg give one tablet via g-tube every 4 hours as needed for agitation" 3/2/2017-"Lorazapam tablet 0.5 mg give one tablet via g-tube every 4 hours as needed for increased agitation" The MAR (Medication Administration Record) for May, June, and July 2017 was examined. All four Lorazapam orders were on these Mar's, but no Lorazapam was administered during that time per these orders. On 7/26/2017 at 10:10 AM an interview was conducted with Employee B, Director of Nursing, who stated that there should not be four separate orders for Lorazapam and did not know how these four orders were on the POS and why no one questioned the order. Administration was informed of the findings on 7/27/2017 at 11:00 AM.	F 386	committee for review. 5. AOC: 9/5/17	

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F 428	Continued From page 52	F 428		
F 428 SS=D	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.45(c)(1)(3)-(5) c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the	F 428		9/5/17

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F 428	Continued From page 53 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review the pharmacy staff failed to identify and report a medication order irregularity to the attending physician. 1. During the monthly medication reviews for Resident #11, the pharmacist noted no irregularities despite there being four orders for Lorazapam on the POS (Physician Order Sheet). Resident #11, a 52 year old female, was admitted to the facility on 12/13/2016 and readmitted on 2/17/2017. Resident #11's diagnoses included CVA (Cerebral Vascular Accident-stroke), epilepsy, anxiety, lupus, anemia, and hypertension. Resident #11 receives nutrition via a feeding tube implanted in the stomach. Resident #11's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/27/2017 was coded as a quarterly assessment. Resident #11 was coded as having	F 428	1. Resident # 11 experienced no ill effects as a result of the duplicative order for as needed lorazepam as it was not ever administered per those orders. Resident # 11's orders were reconciled on 7/27/17. 2. Any resident receiving medications within the facility has the ability to be affected by duplicative orders not noted by pharmacist at required monthly review. An audit will be done of current resident□s last visit and signing of orders to ensure that medications are not duplicative with corrective action taken as needed. 3. Consultant pharmacist will be re-educated regarding the requirement for monthly comprehensive review of medication profiles and reporting of irregularities found.	

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F 428	Continued From page 54 severe cognitive impairment by a staff assessment. She was coded as being totally dependent on 2-3 persons for her activities of daily living, and as being always incontinent of bowel and bladder. On 7/25/2017 at 11:00 AM a review of Resident #11's clinical record was conducted and it revealed the latest POS (Physician Order Sheet) dated 6/27/2017. This POS contained the following duplicate orders for Lorazapam, a sedative: 5/5/2017-"Lorazapam tablet 0.5 mg (milligram) give 0.25 mg via g-tube every 6 hours as needed for anxiety" 5/7/2017-"Lorazapam tablet 0.5 mg give 0.5 tablet via g-tube every 4 hours as needed for agitation" 5/4/2017-"Lorazapam tablet 0.5 mg give one tablet via g-tube every 4 hours as needed for agitation" 3/2/2017-"Lorazapam tablet 0.5 mg give one tablet via g-tube every 4 hours as needed for increased agitation" The monthly pharmacy review for Resident #11's medications took place on 6/13/2017 and 7/14/2017. On both occasions the pharmacist noted "No irregularity". The MAR (Medication Administration Record) for May, June, and July 2017 was examined. All four Lorazapam orders were on these Mar's, but no Lorazapam was administered during that time per these orders.	F 428	4. The DON/designee will audit at least 15 pharmacy consultant review of medications monthly times 3 months to ensure duplications and irregularities are noted and recommendations are received for corrective action. 5. AOC: 9/5/17	

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F 428	Continued From page 55 On 7/26/2017 at 10:10 AM an interview was conducted with Employee B, Director of Nursing, who stated that there should not be four separate orders for Lorazapam and did not know how these four orders were on the POS and no one brought it to the attention of the physician. Administration was informed of the findings on 7/27/2017 at 11:00 AM.	F 428		