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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 3/7/17 through 3/9/17. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 180 certified bed facility was 167 at the time of the survey. The survey sample consisted of 24 current Resident reviews (Residents 1 through 23 and Resident 29) and 5 closed record reviews (Residents 24 through 28).	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
F 160 SS=D	483.10(f)(10)(v) CONVEYANCE OF PERSONAL FUNDS UPON DEATH (v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to convey funds upon death for one of 29 residents in the survey sample, Resident #25. For Resident #25, facility staff failed to convey funds within thirty days after her death on 12/28/17. A check was written to her family on 3/8/17.	F 160		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Reeton | TITLE: ADMINISTRATOR | (X6) DATE: 3-30-17

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The findings include:

Resident #25 was admitted to the facility on 3/01/16 with diagnoses that included but were not limited to dementia without behavioral disturbance, chronic pain, high blood pressure, age related osteoporosis, major depressive disorder and generalized anxiety disorder. Resident #25's most recent MDS (minimum data set) was a death in facility assessment with an ARD (assessment reference date) of 12/28/16.

On 3/8/17 at approximately 10:00 a.m., Resident #25's resident account fund was requested from the DON (Director of Nursing), ASM (administrative staff member) #2. The business office manager could not be found in her office.

On 3/8/17 at 5:20 p.m. at the end of day meeting, Resident #25's resident account fund was requested for the second time from the DON, ASM #2 and ASM #1, the administrator.

On 3/9/17 at 9:40 a.m., Resident #25's resident account fund was requested by OSM (other staff member) #8, the business office manager. OSM #8 stated, "I gave that information to (Name of Administrator). I just closed her account yesterday. It was an oversight because we switched companies. All accounts were closed twice and then re-opened. I feel terrible about it. I called the family and apologized and told them I will send a check in the mail." When asked the appropriate time frame to convey funds, OSM #8 stated, "It is supposed to be within thirty days after death."

Review of Resident #25's statement documented

1. A check was written to the responsible party on 3/8/17.

2. Any resident who has a resident trust account has the potential of being affected.

3. A resident trust review was conducted to verify that trust balances were closed within thirty days. The business office manager was re-educated on the policy regarding closing resident trust accounts.

4. The Administrator will meet with the business office manager weekly to ensure that discharge resident trust accounts are closed within thirty days. Results of the weekly meeting will be reviewed at the monthly QAPI meeting for three months to ensure compliance.

5. Compliance Date: 4/7/17

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Review of Resident #25's statement documented

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F 160	Continued From page 2 the following; "Current Balance $78.00...Status reason: Expired 12/28/16." A document signed by OSM #8 was attached to the resident's statement and documented the following: "3/8/17 Account closed and check (check number) written to be mailed; Contacted RP (Responsible party) (Name of RP), to apologize for the delay and advised the check will be mailed 3/9/17." On 3/9/17 at 10:55 a.m., ASM #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, "Resident Trust Fund Policies," documents in part, the following: "When a patient whose funds are held and managed by the Living Center in (sic) the Resident Trust Funds expires or is permanently discharged, the Business Office will ensure that the balance of the account is refunded, and a full accounting provided, within 30 days if expiration or discharge to the: patient or legal representative, individual or probate jurisdiction administering the patient's estate OR other agency or entity, as required or allowed by state regulation or case--specific notification of fund disbursement..."	F 160		
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. (i)(1) A safe, clean, comfortable, and homelike	F 252		

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F 252	Continued From page 3 environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record interview, it was determined that the facility staff failed to maintain a clean, comfortable, homelike environment for one of 92 resident rooms (room number B10A); and for one of 29 residents in the survey sample, Resident #11; and in two of three facility shower rooms (A unit and B unit). 1. A black substance (approximately five inches long) was observed in the crevice between the tile cove base and tile floor in the bathroom of room number B10A. 2. The facility staff failed to ensure that Resident #11's bathroom was maintained in a clean and safe manner. 3. The facility staff failed to maintain two of three shower rooms (A unit and B unit) in a safe, sanitary and homelike environment. The findings include: 1. A black substance (approximately five inches	F 252	F252 1. Resident bathrooms in room 10 and 20 have been cleaned. Each shower room has been deep cleaned. 2. Each resident bathroom and shower room has the potential of being affected. 3. Health Care Services employees will be re-educated on the proper technique of cleaning which includes but is not limited to: deep cleaning, discharge cleaning and routine cleaning. Staff will attend a refresher in-service every two weeks to ensure their understanding of proper cleaning techniques. 4. Weekly visits by the district director will be made for four weeks then monthly for three weeks. Results of the visits will be reviewed at the monthly QAPI meeting for three months to ensure compliance. 5. Compliance Date: 4/7/17	

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long) was observed in the crevice between the tile cove base and tile floor in the bathroom of room number B10A.

On 3/7/17 at 3:55 p.m., observation of the bathroom in room number B10A was conducted. A black substance (approximately five inches long) was observed in the crevice between the tile cove base and tile floor in the bathroom. The area was observed in the right corner under the sink (while facing the sink).

On 3/7/17 at 4:20 p.m., an interview was conducted with CNA (certified nursing assistant) #4. CNA #4 stated the nursing staff straighten up residents' bathrooms and wipe up stool but the housekeeping department cleans up after the CNAs clean. CNA #4 was shown the black substance in the bathroom of room B10A. CNA #4stated, "I can't tell what that is- dirt, mold or what." CNA #4 was asked if the bathroom looked clean and homelike. CNA #4 stated, "No."

On 3/7/17 at 4:25 p.m., an interview was conducted with OSM (other staff member) #4 (a housekeeper). OSM #4 stated the housekeeping department conducts a "walk through" every morning and sweeps rooms, takes out trash, wipes over-bed tables and mops if needed. OSM #4 stated during the "walk through" housekeeping staff also makes sure toilets, mirrors and sinks are clean. OSM #4 stated after the 10:00 a.m. break, the housekeeping staff conducts detailed cleaning by dusting, cleaning the windows and cleaning over the dressers. OSM #4 stated the area between the cove base and floor tile in the bathroom was cleaned during the detailed cleaning. OSM #4 was shown the black substance in the bathroom of room B10A. OSM

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#4 stated that area should be cleaned during the detailed cleaning every day. OSM #4 was asked if that area should look the way it looked, OSM #4 stated, "some rooms you can scrape all day." OSM #4 stated some elbow grease would be needed to clean that area. OSM #4 stated she couldn't tell this surveyor what the black substance was. When asked if the bathroom looked clean and homelike, OSM #4 stated, "No."

On 3/8/17 at 5:00 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above findings.

The facility document titled, "BATHROOM CLEANING" documented, "B. Follow 7-Step Method...Job: Step 7, Damp Mop Floor...Step #3-Mop corners and edges. 1. Apply pressure on edges and baseboards. 2. Use foot on top of mop in corners to 'dig' out debris. 3. Use Scraper to clean buildup..."

No further information was presented prior to exit.

2. The facility staff failed to ensure that Resident #11's bathroom was maintained in a clean and safe manner.

Resident #11 was admitted to the facility on 12/4/16 with diagnoses that included, but were not limited to, dementia, high blood pressure, a history of rectal prolapse and heart failure.

Resident #11's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/10/16, coded Resident #11 as having a BIMS (brief interview of mental status) score of seven out of a possible

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score of 15, indicating that Resident #11 is cognitively severely impaired.

On 3/17/17 at 11:45 a.m. an observation was made of Resident #11 sitting on the edge of her bed in her room. An inspection was made at this time of her bathroom, shared by Resident #11 and her roommate. The following observations were made;
- The bathroom was observed to have a layer of dust on the heating vent situated on the lower part of the wall on the left side of the entrance into the bathroom.
- A wheelchair cushion was observed on the floor and propped against the wall, also with a layer of dust across the top.
- Along the top edge of the tile baseboard behind the commode extending beneath the sink a dust/ gray colored grime was observed.
- Behind the commode a 0.5" gap was observed at the base of the baseboard and a thick black substance was observed in the gap.
- The sink was attached to the wall and grout around the sink was observed with areas of a brown substance and cracks in multiple areas all around the back edge of the sink.
- Behind the commode an old toilet roll was observed on the floor and appeared to be wet.
- The floor was observed with dark colored grime in multiple areas.
- The wall behind the commode had some stains that had the shape of a hand and finger tips.
- There was no threshold observed at the entrance point into the bathroom, there was a gap between the living area floor and bathroom floor where the threshold would be positioned, in this space thick, black colored grime was observed.
- Handrails were observed secured to the wall behind the commode, and were positioned on

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either side of the commode. The wall plates where the handrails were secured to the wall were observed with a pale substance that was streaked down the plate and there was a thick layer of dust on the portion of the plate that secured the hand rails.
- The hand rails were observed to have the ability to lift upwards and out of the way. When in their lowered position the hand rails were easily moved from side to side and the bolts in the left handrail plate were loose in the wall.

On 3/8/17 at 10:20 a.m. Resident #11 was observed walking around her bathroom and at the sink washing her hands. There was no toilet tissue observed in the bathroom. On inspection the bathroom was observed to be in the same condition as described above. The empty toilet roll was observed to be in the same position behind the commode.

On 3/8/17 16 2:40 p.m. an interview was conducted with OSM (other staff member) #9, the housekeeper on the hallway where Resident #11's room was located. OSM #9 was asked how often she cleaned the resident rooms. OSM #9 stated that she cleaned two to three times per day. When asked if that included the resident bathrooms, OSM #9 stated that it did. When asked what cleaning performed, OSM #9 stated that she did the "high/low dusting" and then swept and mopped the bathrooms. OSM #9 further stated, "I clean everything." OSM #9 was asked if she had already cleaned Resident #11's room and bathroom on this day, OSM #9 stated that she had. This writer asked OSM #9 to accompany her into Resident #11's bathroom. OSM #9 was asked whether or not the bathroom was clean, OSM #9 did not answer the question.

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ASM (administrative staff member) #2, the director of nursing, was asked to observe Resident #11's bathroom at this time. ASM #2 was asked whether or not the bathroom was clean. ASM #2 stated that it was not clean. ASM #2 called OSM #2, the director of maintenance, into the room at this time to address the hand rails beside the commode. When OSM #2 was asked how much side to side "play" the handrails should have, OSM #2 stated that they should not be completely without side to side movement. OSM #2 was observed moving the hand rails side to side and then stated, "These rails have too much side to side play, and the bolts are not completely secure in the wall. I will get this fixed."

A review of the facility housekeeping protocol, dated and signed by the administrator on 3/8/7 at 4:04 p.m., revealed, in part, the following documentation; "DRY steps: 1. Pull trash. Wipe can and if necessary replace liner. 2. Fill dispensers Soap, paper, etc., 3. Dust mop. Pick up trash, use dust mop. WET Steps: 4. Sanitize sinks, light, mirror, sink, fixtures and pipes. 5. Sanitize commode, tank, bowl & base. Use brush for inside of bowl. 6. Spot clean - Walls, partitions, light switches. 7. Damp mop. Start in far corner. Get behind commode, move trash can, mop out the door.

On 3/8/16 at 5:00 p.m. an end of day meeting was held with ASM #1, the administrator. ASM #1 was made aware of the above findings.

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

3. The facility staff failed to maintain two of three

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shower rooms in a safe, sanitary and homelike environment.

Observation was made of the B unit shower room on 3/7/17 at 4:30 p.m. There were three shower areas and one toilet area. The left front shower area had a brush and a used glove on the floor under a bench style seat. A wheel, that appeared to be a wheelchair wheel, was also located under the bench seat. There was something tan colored with red edges on it on the floor with an ant crawling on it. The toilet room was observed with standing water on the floor. The back left shower had three gloves on the floor under the bench style seat. In the shower room, band aids were observed on the floor drain. To the right of the floor drain, were paper packages from band aids and band aids on the floor. The band aids were all wet, and it could not be determined if they were used. The floor drain was covered two thirds of the way with a collection of hair. The lower foot of the wall was covered in a pink/tan substance. In the bench style seat area, a black substance was observed where the floor meets the walls. This area was approximately five inches in length and three quarters of an inch in width. A brush was observed located behind a hand rail, the bristles were tan/brown in color. The right back shower room had standing water all over the floor. The floor drain was covered two thirds of the way with a collection of hair.

An observation was made of the A unit shower room on 3/8/17 at 8:10 a.m. This surveyor was standing outside the shower room, near the nurse's station. The outside wall of the shower room, in the hallway, was observed with paint that was buckling approximately one foot by three feet. The walls were made of cinderblock. Once

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a key was obtained to enter the shower room, a standard sitting chair was observed in the shower room with what appeared to be feces smeared all over the seat. There were three shower areas and one toilet area. Standing water was observed in the toilet room. The back right shower room was observed with what appeared to be feces smeared on the shower curtain. There was a collection of hair observed over the floor drain. The back left shower room was observed with a black/green/brown substance on the tile below the handles and temperature gauge on the walls approximately six inches in width all the way from the handles to the floor.

The administrator (administrative staff member - ASM #1) came to the unit at approximately 8:45 a.m. on 3/8/17. He was shown the above concerns. The director of housekeeping, other staff member (OSM) #1 was with the administrator. When asked if he would shower in this bathroom in the condition it was in, OSM #1 stated, "No, Ma'am." OSM #1 informed this surveyor that his staff was cleaning the B unit shower room also.

An interview was conducted with the administrator on 3/9/17 at 8:58 a.m. When asked how the housekeeping staff is informed of things that are in need of cleaning, ASM #1 stated, "We do room rounds every day. We make a list for housekeeping of things that need to be addressed. The next morning the room round sheets from the previous day are reviewed and we see if they were corrected from the previous day."

The administrator presented a policy on cleaning the bathrooms on 3/8/17 at 4:04 p.m. The policy,

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ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

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F 252	Continued From page 11	F 252		

"Bathroom Cleaning" documented in part, "Step 6, Spot Clean Walls and/or Partitions: 1. Start from the door and work your way around the room clockwise. Pay special attention near trash cans. 3. Any area that people touch every day are very important to wipe (light switches, door handle, cabinet handles) 4. Use brush on stubborn stains...Step 7, Damp Mop Floor: 1. Place wet floor sign in a visible location in the doorway. Mop should be wrung out as thoroughly as possible. Apply pressure on edges and baseboards. Use foot on top of mop in corners to 'dig out' debris. Use scraper to clean buildup. Use a figures eight motion starting in the back of the room. Make sure area under sinks and behind commodes are mopped. Use foot on top of mop in corners to 'dig' out debris. Make sure no refuse is left in doorway. Water should be changed if you can't see the bottom of bucket."

The administrator was made aware of the above findings on 3/8/17 at 5:15 p.m.

On 3/9/17 at 8:30 a.m., a tour of the facility was conducted with ASM #1, the administrator, OSM #1, director of housekeeping and OSM #2, the director of maintenance. The A unit and B unit shower rooms were inspected. The B unit shower room still contained the black/green/brown substance in the back left shower room where the wall meets the floor and the pink/tan substance on the bottom of the walls in the back left shower room. OSM #2 was asked if the shower room was cleaned yesterday, OSM #2 stated, "Yes."

The administrator presented a copy of a policy on 3/9/17 at 9:20 a.m. The policy, "Performance Improvement Care Keeper Rounds (Quality

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Assurance)" documented in part, "1. Members of the Care Keeper rounding team may include: a. Director of Nursing, b. Activities Director, c. Social Worker, d. Dietary manager, e. Assistant director of nursing, f. Clinical Nurses/Supervisors, g. Rehab Director, h. Administrator, i. Any other member of facility that may be attending morning meeting. 2. Each member will select approximately 8 - 10 residents (consecutive room numbers) on a unit. 3. There will be at least two members for approximately 20 residents and they will work together as a team. 4. Each partner will obtain information about their residents to complete the Resident Care Keeper Form. Each member will provide their partner with a copy of their Resident Care Keeper Form. IN the event one of the partners on the unit is not available, their partner will monitor both their residents and the partner's residents. Each partner will maintain the monitoring from in an easily accessible area and update as needed. 5. Each member will obtain and complete a Care Keeper rounding form daily between 8 a.m. and 9 a.m. and at another time during that day. 6. Observations of resident and rooms will be documented on the form. 7. The observations will be discussed at morning meeting and forwarded to QA (Quality Assurance) committee. 8. Items may be added to the Care Keeper Rounding list as determined by each facility (i.e. Deficiencies cited during survey)."

No further information was provided prior to exit.

F 272 SS=D 483.20(b)(1) COMPREHENSIVE ASSESSMENTS — F 272

(b) Comprehensive Assessments

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F 272	Continued From page 13 (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.	F 272	F272 1. Resident #1 has expired. Resident #9 and #10 CAA's were completed with the date and location of information on 3/21/17. 2. Each resident's MDS has the potential of being affected. 3. Comprehensive assessments were reviewed for completion with dates and locations. Corrections were made as necessary. The Interdisciplinary Team (IDT) was re-educated on CAA completion. 4. CAA worksheets will be completed and reviewed by the Director of Nursing Services or designee for completion with date and location of information weekly for four weeks then monthly for three months. Results will be reviewed at the monthly QAPI meeting for three months to ensure compliance. 5. Compliance Date: 4/7/17	

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The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.

This REQUIREMENT is not met as evidenced by:

Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to document date and location information on the CAA Summary for 3 of 29 residents in the survey sample; Residents #1, #9, and #10.

1. The facility staff failed to document the date and location of the information obtained from the clinical record that was used to complete Resident #1's annual assessment with an ARD (assessment reference date) of 7/15/167/15/16 MDS.

2. The facility staff failed to document the date of information from the clinical record that was utilized to complete the assessment of the triggered areas, on Resident #9's annual MDS assessment with an ARD of 10/27/16.

3. The facility staff failed to document the location and date of information from the clinical record that was utilized to complete the assessment of the triggered areas, on Resident #10's significant change MDS assessment with an ARD of 1/20/17.

The findings include:

1. Resident #1 was admitted to the facility on 6/14/13 with the diagnoses of but not limited to: stroke, hemiplegia, hemiparesis, chronic

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obstructive pulmonary disease, glaucoma, cardiomegaly, pressure ulcer, bladder disorder, depression, diabetes, high cholesterol, delusional disorder, psychosis, and mood disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/13/17. The resident was coded as being mildly cognitively impaired, scoring a 12 of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.

A review of the clinical record revealed the most recent comprehensive MDS, an annual assessment with an ARD of 7/15/16. Review of Section V, the Care Area Assessment Summary (CAA) revealed the resident triggered for the areas of: 01. Delirium, 02. Cognitive Loss/Dementia, 03. Visual Function, 04. Communication, 05. ADL Functional/Rehabilitation Potential, 06. Urinary Incontinence and Indwelling Catheter, 11. Falls, 12. Nutritional Status, 14. Dehydration/Fluid Maintenance, 15. Dental Care, 16. Pressure Ulcer, 17. Psychotropic Drug Use, and 19. Pain. With the exception of area 12. Nutritional Services, next to each area was documented "CAA WS (worksheet) dated 8/31/16" under the column for "Location and Date of CAA documentation." A review of the CAA worksheet for each of these areas failed to identify any clinical record source of documentation used to complete the MDS assessment.

On 3/8/17 at 10:36 a.m., in an interview with RN #7 (Registered Nurse), the MDS nurse, she stated that she did not know why the CAA summary was not completed with date and location information, and that the nurse who did that (on Resident #1's assessment) was no

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longer there.

No further information was provided by the end of the survey.

Section V of the MDS documents at the top of the page the following instructions:

1. Check column A if the Care Area is triggered.

2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Addressed in the Care Plan column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.

3. Indicate in the Location and Date of CAA information column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks and any referrals for this resident for this care area.

Review of CMS's (Center of Medicare/Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 User's Manual documented, "CHAPTER 4: CARE AREA ASSESSMENT (CAA) PROCESS AND CARE PLANNING. 4.5 Other Considerations Regarding Use of the CAAs. Use the "Location and Date of CAA Documentation" column on the CAA Summary (Section V of the MDS 3.0) to note where the CAA information and decision making documentation can be found in the resident's record. Also indicate in the column "Care

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Planning Decision" whether the triggered care area is addressed in the care plan."

2. The facility staff failed to document the date of information from the clinical record that was utilized to complete the assessment of the triggered areas, on Resident #9's annual MDS assessment with an ARD of 10/27/16.

Resident #9 was admitted to the facility on 11/16/15 with diagnoses that included but were not limited to atrial fibrillation, COPD (chronic obstructive pulmonary disease), liver cirrhosis, and major depressive disorder. Resident #9's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/12/17. Resident #9 was coded as being severely cognitively impaired scoring a 03 of 15 on the BIMS (Brief Interview for Mental Status) exam.

A review of the clinical record revealed the most recent comprehensive MDS assessment was an annual MDS assessment with an ARD (assessment reference date) of 10/26/16 for Resident #9. Part A, "CAA (Care Area Assessment Summary) results" under Section V "Care Area Assessment Summary" of the annual assessment MDS documented that Resident # 9 triggered for the following CAA areas: "Cognitive function, communication, ADL (Activities of Daily Living) Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Pressure Ulcer, and psychotropic drug use and physical restraints." The following was documented under the "Location and Date" column for CAA triggered area "Nutritional Status:" "See nutritional assessment." Review of the CAA worksheets

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F 272	Continued From page 18 failed to reveal the date of information used for the triggered area, "Nutritional Status." On 3/8/17 at 11:18 a.m., an interview was conducted with RN (registered nurse) #4, an MDS coordinator. When asked about the process for the location and date of information used to complete the MDS assessment, RN #4 stated, "I review the CAA to determine why the areas triggered and document where the information came from in the clinical record and the date of the information. I sign and date the CAA and then decide whether to care plan that area." RN #4 stated that she did not see a date for the nutritional assessment that was identified in section V. RN #4 stated, "That would be a matter of educating dietary." RN #4 stated that facility use the RAI (Resident Assessment Instrument Manual) as a reference when completing Section V of the MDS. On 3/8/17 at 5:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. 3. The facility staff failed to document the location and date of information from the clinical record that was utilized to complete the assessment of the triggered areas, on Resident #10's significant change MDS assessment with an ARD of 1/20/17. Resident #10 was admitted to the facility on 6/22/16 with diagnoses that included but were not limited to Dementia with Lewy bodies [1], fracture	F 272		

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of the right femur, type two diabetes, high blood pressure, and major depressive disorder. Resident #10's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 1/21/17. Resident #10 was coded as being cognitively intact in the ability to make daily decisions, scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

A review of the clinical record revealed the most recent comprehensive MDS was a significant change assessment with an ARD (assessment reference date) of 1/21/17 for Resident #10. Part A, "CAA (Care Area Assessment Summary) results" under Section V "Care Area Assessment Summary" of the significant change MDS assessment documented that Resident # 10 triggered for the following CAA areas: "Visual Function, ADL (Activities of Daily Living) Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Mood State, Falls, Nutritional Status, Pressure Ulcer, and psychotropic drug use" The following was documented under the "Location and Date" column for the CAA triggered area "Mood State:" "CAA WS (worksheet) dated 2/16/17." The following was documented under the "Location and Date" column for the CAA triggered area "Pressure Ulcer:" "CAA WS dated 2/3/17." Review of the CAA worksheets failed to reveal the date and location of information for the triggered areas, "Mood State" and "Pressure Ulcer."

On 3/8/17 at 11:18 a.m., an interview was conducted with RN (registered nurse) #4, the MDS coordinator. When asked about the process for the location and date of information

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F 272	Continued From page 20 used to complete the MDS assessment, RN #4 stated, "I review the CAA to determine why the areas triggered and document where the information came from in the clinical record and the date of the information. I sign and date the CAA and then decide whether to care plan that area." RN #4 stated that she did not see the location and date of information for the care areas of "Mood State" and "Pressure" in Section V of the MDS assessment on the CAA worksheets. RN #4 stated that social work would be responsible for completing the mood state section. When asked who was responsible for completing the pressure ulcer section, RN #4 stated that she was responsible and it was an oversight. On 3/8/17 at 5:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. [1] "-LBD is a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain. These deposits, called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood." This information was obtained from The National Institutes of Health. https://www.nia.nih.gov/alzheimers/publication/lewy-body-dementia/basics-lewy-body-dementia.	F 272		
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS (b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility	F 275		

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F 275	Continued From page 21 must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to complete an annual MDS (minimum data set) assessment in a timely manner for 1 of 29 residents in the survey sample; Resident #1. Resident #'s annual MDS assessment with and assessment reference date of 7/15/16 was not completed until 8/31/16. The findings include: Resident #1 was admitted to the facility on 6/14/13 with the diagnoses of but not limited to stroke, hemiplegia, hemiparesis, chronic obstructive pulmonary disease, glaucoma, cardiomegaly, pressure ulcer, bladder disorder, depression, diabetes, high cholesterol, delusional disorder, psychosis, and mood disorder. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/13/17. The resident was coded as being mildly cognitively impaired, scoring a 12 of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1 was coded as requiring total care for bathing; extensive assistance for hygiene, dressing, and transfers; as independent for eating; and was	F 275	F275 1. Resident #1 expired. 2. Each resident's MDS has the potential of being affected. 3. A calendar for annual assessments due for the remainder of the year was implemented. Both MDS Coordinators were re-educated to OBRA timing of assessments. 4. The Director of Nursing Services or designee will review the MDS calendar for timeliness weekly for four weeks then monthly for three months. The results will be reviewed at the monthly QAPI meeting for three months to ensure compliance. 5. Compliance Date: 4/7/17	

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F 275	Continued From page 22 coded as incontinent of bowel and bladder. A review of the annual comprehensive MDS with an ARD of 7/15/16 revealed that the Care Area Assessment (CAA) worksheet summary documentation used to complete this MDS was completed and dated 8/31/16; approximately 6 weeks after the ARD. Section Z0500 "Signature of RN Assessment Coordinator Verifying Assessment Completion" was dated 8/31/16. On 3/8/17 at 10:36 a.m., during an interview RN #7 (Registered Nurse) an MDS nurse stated that at one time, the facility was behind on completing the MDS assessments, but that she was not sure why this assessment was approximately 6 weeks late. She stated the nurse that completed it was no longer at the facility. No further information was provided by the end of the survey. According to the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 July, 2010, page 2-19: " The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless a SCSA (Significant Change in Status Assessment) or a SCPA (Significant Correction to Prior Assessment) has been completed since the most recent comprehensive assessment was completed..."	F 275		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment	F 278		

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F 278	Continued From page 23 must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain an accurate MDS (minimum data set) assessment for two of 29 residents in the survey sample, Residents #4	F 278	F278 1. Resident #4 MDS was modified on 3/9/17. Resident #16 was modified on 3/20/17. 2. Each resident's MDS has the potential of being affected. 3. The height and weight on MDS's were reviewed for proper coding and the use of the dash. The IDT was re-educated on the proper use of dashes on the MDS. 4. The Director of Nursing Services or designee will review the height and weight on the MDS weekly for four weeks then monthly for three months to ensure compliance. Results will be reviewed at the monthly QAPI meeting for three months to ensure compliance. 5. Compliance Date: 4/7/17	

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and #16.

1. The facility staff failed to accurately code Resident #4's height on an annual MDS assessment with an ARD (assessment reference date) of 12/29/16.

2. The facility staff failed to accurately code Resident #16's height and weight section on the significant change MDS assessment with an ARD (assessment reference date) of 12/28/16.

The findings include:

1. The facility staff failed to accurately code Resident #4's height on an annual MDS assessment with an ARD (assessment reference date) of 12/29/16.

Resident #4 was admitted to the facility on 1/16/15. Resident #4's diagnoses included but were not limited to: high blood pressure, muscle weakness and constipation. Resident #4's most recent MDS, a significant change in status assessment with an ARD of 1/29/17, coded the resident's cognitive skills for daily decision making as moderately impaired. Section K coded the resident's height as 60 inches. Section K of Resident #4's annual MDS assessment with an ARD of 12/29/16 coded the resident's height as 99 inches.

On 3/8/17 at 11:07 a.m., an interview was conducted with RN (registered nurse) #3 and RN #4 (both MDS coordinators) regarding the discrepancy in heights on the above MDS assessments. RN #4 stated at one time, staff was coding "99" on the MDS if staff was unable to obtain a resident's height. RN #4 stated

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currently, a dash was supposed to be coded if staff was unable to obtain a resident's height. When asked if the 12/29/16 MDS was inaccurately coded, RN #4 stated, "It would be a matter of educating the dietician or dietary manager." RN #3 stated the dietician was responsible for entering residents' heights on the MDS assessments and the dietician was only employed part time. RN #3 stated the dietician didn't have a RAI (resident assessment instrument) manual (the manual referenced by the facility when completing MDS assessments) in her office but could speak to the MDS coordinators if she had questions. RN #3 stated the dietician probably thought she was still supposed to code "99" if staff was unable to obtain a resident's height.

On 3/8/17 at 5:00 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern.

The CMS (Centers for Medicare and Medicaid Services) RAI manual documented the following:

"Coding Instructions for K0200A, Height
Record height to the nearest whole inch. Use mathematical rounding (i.e., if height measurement is X.5 inches or greater, round height upward to the nearest whole inch. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch). For example, a height of 62.5 inches would be rounded to 63 inches and a height of 62.4 inches would be rounded to 62 inches..."

Further guidance documents, "If a resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological

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fractures, use the standard no-information code (-) and document rationale on the resident's medical record..."

No further information was presented prior to exit.

2. The facility staff failed to accurately code Resident #16's height and weight section on the significant change MDS assessment with an ARD (assessment reference date) of 12/28/16.

Resident #16 was admitted to the facility on 4/27/12 with the diagnoses of but not limited to anoxic brain damage, pathological hip fracture, bipolar disorder, and epilepsy. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 12/28/16. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident required total care for all areas of activities of daily living and was incontinent of bowel and bladder.

A review of the above identified MDS revealed in Section K "Swallowing / Nutritional Status," in section K0200 Height and Weight, the resident was coded as 99 inches [A. Height (in inches) Record most recent height measure since the most recent admission/entry or reentry.] The resident was coded as 999 pounds [B. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)]

On 3/8/17 at 10:36 a.m., in an interview with RN #7 (Registered Nurse) the MDS nurse, she stated

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that since this section is usually coded with numbers to reflect height and weight, that if there is no height and weight to code, then the section should be dashed (-) instead of using 99 or 999 to reflect that height and weight information was not available. She stated this was a coding error.

No further information was provided by the end of the survey.

According to CMS's RAI (Centers for Medicaid and Medicare Services Resident Assessment Instrument) Version 3.0 Manual:

Steps for Assessment for K0200A, Height
1. Base height on the most recent height since the most recent admission/entry or reentry. Measure and record height in inches.
2. Measure height consistently over time in accordance with the facility policy and procedure, which should reflect current standards of practice (shoes off, etc.).
3. For subsequent assessments, check the medical record. If the last height recorded was more than one year ago, measure and record the resident's height again.

Coding Instructions for K0200A, Height
- Record height to the nearest whole inch.
- Use mathematical rounding (i.e., if height measurement is X.5 inches or greater, round height upward to the nearest whole inch. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch). For example, a height of 62.5 inches would be rounded to 63 inches and a height of 62.4 inches would be rounded to 62 inches.

Steps for Assessment for K0200B, Weight

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F 278	Continued From page 28 1. Base weight on the most recent measure in the last 30 days. 2. Measure weight consistently over time in accordance with facility policy and procedure, which should reflect current standards of practice (shoes off, etc.). 3. For subsequent assessments, check the medical record and enter the weight taken within 30 days of the ARD of this assessment. 4. If the last recorded weight was taken more than 30 days prior to the ARD of this assessment or previous weight is not available, weigh the resident again. 5. If the resident's weight was taken more than once during the preceding month, record the most recent weight. Coding Instructions for K0200B, Weight · Use mathematical rounding (i.e., If weight is X.5 pounds [lbs] or more, round weight upward to the nearest whole pound. If weight is X.1 to X.4 lbs, round down to the nearest whole pound). For example, a weight of 152.5 lbs would be rounded to 153 lbs and a weight of 152.4 lbs would be rounded to 152 lbs. · If a resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (-) and document rationale on the resident's medical record.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care	F 279		

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F 279	Continued From page 29 plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and	F 279	F279 1. Resident #6's care plan was updated to include visual function. Resident #7's care plan was updated to include care needs related to her history of a mastectomy. Resident #11's care plan was updated to include cognition, visual function and communication. 2. Each resident's care plan has the potential of being affected. 3. The comprehensive assessments were reviewed for triggered CAA's selected for care planning to ensure the presence on the care plan. The IDT was re-educated to proper CAA completion and care plan decision making to formulate the care plan.	

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F 279	Continued From page 30 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to develop a comprehensive care plan for three of 29 residents in the survey sample, Resident #6, Resident #7 and Resident #11. 1. The facility staff failed to develop a comprehensive care plan for the triggered care area of visual function on Resident #6's annual MDS (minimum data set), with an ARD (assessment reference date) of 6/16/17. 2. The facility staff failed to develop a care plan to address the care needs related to Resident #7's history of a left mastectomy. 3. The facility staff failed to develop a comprehensive care plan for the triggered care areas on Resident #11's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/10/16. The findings include:	F 279	4. The Director of Nursing services or designee will review CAA's and care plans for inclusion of triggered CAA's and care plan completion weekly for four weeks then monthly for three months. Results will be reviewed at the monthly QAPI meeting for three months to ensure compliance. 5. Compliance Date: 4/7/17	

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1. Resident #6 was admitted to the facility on 10/5/06 and readmitted on 5/1/12 with diagnoses that included but were not limited to: high blood pressure, Parkinson's disease (1), dementia, irregular heart beat and arthritis.

The most recent minimum data set, a quarterly assessment, with an assessment reference date of 2/2/17 coded the resident as having long and short term memory problems and as impaired cognitively to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the annual MDS with an ARD of 6/3/16 CAA section documented, "Visual Function. Check all that apply. Care Area Triggered (there was an "x" in the box) Care Planning Decision (there was an "x" in the box)."

Review of Resident #6's care plan initiated on 12/15/11 did not evidence documentation related to visual function.

An interview was conducted on 3/8/17 at 11:05 a.m. with RN (registered nurse) #3 and RN #4, MDS coordinators. When asked about the process for developing a care plan from the CAA, RN #3 stated, "We sign and date the CAA. We make a decision to care plan it." RN #4 reviewed Resident #6's CAA from the 6/3/16 MDS assessment. When asked if the resident had impaired vision, RN #4 stated she did. When asked if a care plan should have been developed, RN #4 stated, "Yes, because she had impaired vision we should have done a care plan." RN #4 reviewed Resident #6's care plan. When asked if there had been a care plan developed for visual function, RN #4 stated, "No." When asked what

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manual they used for completing the MDS assessments, RN #4 stated they used the RAI (resident assessment instrument).

On 3/8/17 at 5:00 p.m. ASM (administrative staff member) #1, the administrator was made aware of the findings.

The RAI documented, "OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required."

No further information was provided prior to exit.

(1) Parkinson's disease -- Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families. Exposure to chemicals in the environment might play a role. This information was obtained from: https://medlineplus.gov/parkinsonsdisease.html

(2) Atrial fibrillation - An arrhythmia is a problem with the speed or rhythm of the heartbeat. Atrial fibrillation (AF) is the most common type of arrhythmia. The cause is a disorder in the heart's electrical system. This information was obtained from: https://medlineplus.gov/atrialfibrillation.html

2. Resident #7 was admitted to the facility on

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F 279	Continued From page 33 12/18/15 and readmitted on 11/29/16 with diagnoses that included but were not limited to: left mastectomy, stroke, high blood pressure and depression.	F 279		

Review of the most recent MDS, a significant change assessment, with an ARD of 1/7/17 coded the resident as having scored 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the nurse's note dated 12/18/15 documented, "A few small scars on buttock and extremities, and large scar left chest where breast has been removed."

Review of the clinical health status notes dated 11/29/16 documented, "Skin Concern #1. Site: (Left) side of chest. Description: surgical scar from mastectomy."

Review of the care plan initiated on 2/5/16 and revised on 11/16/16 did not evidence documentation regarding Resident #7's history of having a left mastectomy.

An interview was conducted on 3/9/17 at 9:15 a.m. with LPN (licensed practical nurse) #1, the unit manager. When asked who used the care plan, LPN #1 stated, "MDS and nursing," When asked why a resident had a care plan, LPN #1 stated, "It's to lay out their care." When asked if Resident #7 had a care plan related to her mastectomy, LPN #1 stated, "She should have." LPN #1 reviewed the care plan and stated there was no care plan for the mastectomy. When

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asked if there was any special care provided to residents with mastectomies, LPN #1 stated, "You don't take a blood pressure on that arm."

An interview was conducted on 3/9/17 at 9:45 a.m. with LPN #12, the nurse caring for Resident #7. When asked if there was any special care provided to residents with mastectomies, LPN #12 stated, "Don't do blood pressure checks on that arm. Check that they don't have edema (swelling)." When asked how this would be communicated, LPN #12 stated, "Sometimes they have a sign above their bed not to take them (blood pressure) on that arm." When asked if the resident had a sign over her bed, LPN #12 stated, "No, she doesn't. It should be care planned."

On 3/9/17 at 11:12 a.m. ASM (administrative staff member) #2, the director of nursing was made aware of the findings.

No further information was provided prior to exit.

3. Resident #11 was admitted to the facility on 12/4/16 with diagnoses that included, but were not limited to; dementia, high blood pressure, heart failure and a history of a rectal prolapse.

Resident #11's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 12/10/16. Resident #11 was coded on the BIMS (brief interview of mental status) as having a score of seven out of a possible 15, indicating that Resident #11 was severely cognitively impaired.

Further review of Resident #11's MDS with an ARD of 12/10/16 revealed in Section V-Care Area

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Assessment (CAA), that the care areas "02. Cognitive Loss/Dementia. 03. Visual Function. 04. Communication." were checked under the heading "B. Care Planning Decision" to be care planned." The instruction provided in Section V states, "2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. Check column B if the triggered care area is addressed in the care plan."

A review of Resident #11's comprehensive care plan dated 12/4/2016 did not reveal a care plan to address cognition, vision or communication.

On 3/8/17 at 11:15 a.m. an interview was conducted with RN (registered nurse) #3 and RN #4, both MDS coordinators at the facility. RN #3 was asked who was responsible for developing and updating care plans. RN #3 stated that the unit managers and nursing did input updates on the care plans as well as the MDS coordinators. RN #3 further stated that the MDS coordinators developed the care plans from the CAAs. RN #4 was asked to describe the process of developing a care plan. RN #4 stated that the process would be to review the CAAs, understand why the areas triggered, where the information was located in the clinical data and whether or not a care plan would be developed for the triggered area. RN #3 was asked to review Resident #11's MDS, specifically Section V. RN #3 was then asked to demonstrate where cognition, vision and communication were care planned in Resident #11's care plan. RN #3 reviewed both Section V and Resident #11's care plan and was unable to demonstrate that cognition, vision and

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ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(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 279	Continued From page 36 communication were care planned. RN #3 stated that she did not see those areas care planned. RN #3 further stated, "It is possible we forgot to put them (cognition, vision and communication) in there." RN #3 was asked what she used as a reference when completing the MDS and developing care plans. RN #3 stated that she used the RAI (resident assessment instrument). On 3/8/17 at 5:00 p.m. an end of day meeting was held with ASM (administrative staff member) #1, the administrator. ASM #1 was made aware of the above concerns and a policy was requested for the completion of care plans. On 3/9/17 at 11:30 a.m. ASM #1 stated that he did not have a policy for completion of care plans. No further information was provided prior to the end of the survey process.	F 279		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to follow professional standards for one of 29 residents in the survey sample, Resident #7.	F 281		

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F 281	Continued From page 37 The facility staff failed to prevent staff from taking Resident #7's blood pressure on her left mastectomy arm. The findings include: Resident #7 was admitted to the facility on 12/18/15 and readmitted on 11/29/16 with diagnoses that included but were not limited to: left mastectomy, stroke, high blood pressure and depression. Review of the most recent MDS, a significant change assessment, with an ARD of 1/7/17 coded the resident as having scored 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. Review of the nurse's note dated 12/18/15 documented, "A few small scars on buttock and extremities, and large scar left chest where breast has been removed." Review of the clinical health status notes dated 11/29/16 documented, "Skin Concern #1. Site: (Left) side of chest. Description: surgical scar from mastectomy." Review of the care plan initiated on 2/5/16 and revised on 11/16/16 did not evidence documentation regarding Resident #7's history of having a left mastectomy. Review of the blood pressure summary log from 11/1/16 to 2/15/17 documented that the resident had her blood pressure taken on her left arm on	F 281	F281 1. Resident #7 blood pressure order was clarified to state that no blood pressure is to be taken in the left arm related to her mastectomy. 2. An audit of each resident with a mastectomy will be conducted to ensure orders state that no blood pressure is to be taken in the arm on the side of the mastectomy. 3. Licensed staff will be re-educated on the standards of practice of caring for residents with a diagnosis of mastectomy. 4. The Director of Nursing Services or designee will conduct audits on residents who have had a mastectomy to ensure that blood pressures are being completed according to standards of practice. Audits will be performed weekly for four weeks the monthly for three months. Results will be reviewed at the monthly QAPI meeting to ensure compliance. 5. Compliance Date: 4/7/17	

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12 occasions.

An interview was conducted on 3/9/17 at 9:12 a.m. with OSM (other staff member) #4, the resident's physician. When asked if it would be acceptable for staff to take blood pressures on Resident #7's left arm, OSM #4 stated, "No, it is not advisable. When they do a mastectomy they do a lymph node biopsy. No they shouldn't do blood pressures on the left (arm)."

An interview was conducted on 3/9/17 at 9:15 a.m. with LPN (licensed practical nurse) #1, the unit manager. . When asked if there was any special care provided to residents with mastectomies, LPN #1 stated, "You don't take a blood pressure on that arm." LPN #1 reviewed the blood pressure summary log documenting that blood pressures had been taken on Resident #7's left arm.

An interview was conducted on 3/9/17 at 9:45 a.m. with LPN #12, the nurse caring for Resident #7. When asked if there was any special care provided to residents with mastectomies, LPN #12 stated, "Don't do blood pressure checks on that arm. Check that they don't have edema (swelling)." When asked how this would be communicated, LPN #12 stated, "Sometimes they have a sign above their bed not to take them (blood pressure) on that arm." When asked if the resident had a sign over her bed, LPN #12 stated, "No she doesn't. It should be care planned."

On 3/9/17 at 11:12 a.m. ASM (administrative staff member) #2, the director of nursing was made aware of the findings. When asked what professional standard the nurse's used, ASM #2 stated, "Lippincott." No further information was

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F 281	Continued From page 39 provided prior to exit. According to Lippincott Manual of Nursing Practice Edition 10 documented on page 893, "PATIENT EDUCATION GUIDELINES...To reduce the risk of lymphedema of your arm after the removal of lymph nodes, follow these general guidelines to prevent infection and obstruction of blood and lymph fluid...Avoid having blood pressure taken on affected arm."	F 281		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow the written plan of care for three of 29 residents in the survey sample, Residents #6 and 12 1. Facility staff failed to keep Resident #6's heel protectors on at all times as care planned and ordered by the physician. 2.a. The facility staff failed to follow Resident #12's written plan of care for oxygen administration. b. The facility staff failed to follow Resident #12's	F 282		

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written plan of care for the monitoring of fluid restriction.

The findings include:

1. Facility staff failed to keep Resident #6's heel protectors on at all times as care planned and ordered by the physician.

Resident #6 was admitted to the facility on 10/5/06 and readmitted on 5/1/12 with diagnoses that included but were not limited to: high blood pressure, Parkinson's disease (1), dementia, irregular heart beat and arthritis.

The most recent minimum data set, a quarterly assessment, with an assessment reference date of 2/2/17 coded the resident as having long and short term memory problems and as impaired cognitively to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the physician's orders dated 9/27/16 documented, "Prevalon boots (3) to bilateral feet at all times, remove for hygiene and skin checks every shift."

Review of the February 2017 treatment administration record documented, "Prevalon boots to bilateral feet at all times, remove for hygiene and skin checks every shift."

Review of the care plan initiated on 12/15/11 and revised on 2/15/17 documented, "Focus At risk for Pressure ulcer due to: requires Assist with bed mobility and toileting....edema to lower ext's (extremities). Interventions. Prevalon Boots on at all times except for hygiene and bathing."

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1. A) The physician's order for heel protectors for Resident #6 was clarified by the physician and the care plan has been updated. B) Resident #12 care plan has been reviewed and is being followed for oxygen administration. C) Resident #12 care plan has been reviewed and is being followed for the monitoring of fluid restrictions.

2. A) A review of residents with heel protectors was conducted to ensure utilization as per physician order and is care planned. B) A review of resident oxygen concentrators was conducted to ensure the setting is as per physician orders. C) A review of resident's who are on fluid restrictions was conducted to ensure physician orders were being followed.

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F 282	Continued From page 41 An observation was made on 3/7/17 at 3:35 p.m. of Resident #6. The resident was in bed. The resident was not wearing the heel boots. An observation was made on 3/8/17 at 8:55 a.m. of Resident #6. The resident was sitting in the dining room. She was wearing a white pair of crocs shoes. An observation was made on 3/8/17 at 4:25 p.m. of Resident #6. The resident was in the auditorium. She was wearing the white shoes. An observation was made on 3/9/17 at 9:30 a.m. of Resident #6. The resident was sitting up in a chair next to her bed. She was wearing the white shoes. An interview was conducted on 3/8/17 at 4:25 p.m. with ASM (administrative staff member) #2, the director of nursing and RN (registered nurse) #1, the assistant director of nursing. ASM #2 informed of the above observations. When asked if the resident was to have protective boots on, ASM #2 stated, "(RN #1) is she to have boots?" RN #1 stated, "Yes. She had a heel sore but it's better now." An interview was conducted on 3/9/17 at 9:15 a.m. with LPN (licensed practical nurse) #1, the unit manager. When asked why residents had care plans, LPN #1 stated, "It's to lay out their care." When asked if staff were expected to follow the care plan, LPN #1 stated, "Yes." An interview was conducted on 3/9/17 at 9:38 a.m. with CNA (certified nursing assistant) #2, the aide caring for Resident #6. When asked if the	F 282	3. A) Licensed staff will be re-educated on following the plan of care for heel protectors. B) Licensed staff will be re-educated on following the plan of care for oxygen administration. C) Licensed staff will be re-educated on following the plan of care for the monitoring of fluid restrictions. 4. A) Audits of heel protectors, B) oxygen therapy and C) fluid restrictions will be conducted weekly for four weeks then monthly for three weeks. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 4/7/17	

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resident had heel protectors, CNA #2 stated, "She wears them in the bed at night. We take them off in the morning." When asked how information about the care of the resident was communicated to her, CNA #2 stated, "It's on the care guide." A request to see the care guide was made. Review of the care guide documented, "PROTECTIVE BOOTS ON QS (every shift)." When CNA #2 reviewed the guide she stated, "You're absolutely right. They should be on all the time."

An interview was conducted on 3/9/17 at 9:45 a.m. with LPN (licensed practical nurse) #12, the nurse caring for Resident #6. When asked if the resident was to have heel protectors on, LPN #12 stated, "Let me check. Yes she is." When asked when the protectors should be on, LPN #12 stated, "At all times." When asked how staff knew if the heel protectors were on, LPN #12 stated, "You're going around when you're doing your med (medication) pass and checking to make sure they have everything they need." When asked why a resident had a care plan, LPN #12 stated, "So we know the residents, know particulars (of their care)." When asked if staff followed the care plans, LPN #12 stated, "Yes."

No further information was provided prior to exit.

(1) Parkinson's disease -- Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families. Exposure to chemicals in the environment might play a role. This information was obtained from: https://medlineplus.gov/parkinsonsdisease.html

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(2) Atrial fibrillation - An arrhythmia is a problem with the speed or rhythm of the heartbeat. Atrial fibrillation (AF) is the most common type of arrhythmia. The cause is a disorder in the heart's electrical system. This information was obtained from: https://medlineplus.gov/atrialfibrillation.html

(3) Prevalon boots -- pressure relieving device. This information was obtained from: https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=prevalone+boots&commit=Search

2.a. The facility staff failed to follow Resident #12's written plan of care for oxygen administration.

Resident #12 was admitted to the facility on 2/2/16. Resident #12's diagnoses included but were not limited to: heart failure, diabetes and chronic obstructive pulmonary (respiratory) disease. Resident #12's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 1/17/17, coded the resident's cognition as severely impaired. Section G coded Resident #12 as being independent with setup help only with transfers and locomotion.

Review of Resident #12's clinical record revealed a physician's order summary signed by the physician on 1/29/17 that documented an order for oxygen at two liters per minute via nasal cannula for shortness of breath as needed.

Resident #12's comprehensive care plan initiated on 4/12/16 documented, "Alteration in Respiratory Status r/t (related to) Dx (diagnosis) of COPD

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(chronic obstructive pulmonary disease)...Interventions: Administer oxygen as needed per Physician order..."

On 3/7/17 at 1:30 p.m., observation of Resident #12 was conducted. The resident's oxygen tubing was sitting on the bed while the resident placed lotion on her hands. When asked if she wears her oxygen all the time, Resident #12 stated she was about to put her oxygen back on and placed the nasal cannula back on her face. The ball in the oxygen concentrator flowmeter was observed positioned between the line for one and a half liters and the line for two liters. When asked if she ever adjusts the flowmeter knob on the oxygen concentrator, Resident #12 stated she did not.

On 3/7/17 at 3:35 p.m., Resident #12 was observed wearing the oxygen nasal cannula. The ball in the oxygen concentrator flowmeter was positioned between the line for one and a half liters and the line for two liters.

On 3/8/17 at 11:25 a.m., Resident #12 was observed wearing the oxygen nasal cannula. The ball in the oxygen concentrator flowmeter was positioned between the line for one and a half liters and the line for two liters. This observation was confirmed by another surveyor.

On 3/8/17 at 11:28 a.m., an interview was conducted with LPN (licensed practical nurse) #6 (the nurse caring for Resident #12). LPN #6 was asked to describe where the ball in the oxygen concentrator flowmeter should be located if a resident has a physician's order for two liters; LPN #6 looked at another resident's oxygen concentrator and stated the middle of the ball

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should be at the two liter line. LPN #6 stated Resident #12 knew how to turn her concentrator on and off but she (LPN #6) had not ever seen the resident adjust the flowmeter knob. LPN #6 stated she checks the resident's concentrator once a day to make sure the flowmeter is set at the prescribed rate of two liters. When shown Resident #12's oxygen concentrator, LPN #6 stated, "To me it's on two liters but the ball needs to go up a little bit." LPN #6 adjusted the flowmeter knob so that the middle of the ball was resting on the two liter line. LPN #6 stated the flowmeter ball wasn't completely on two liters and wasn't completely off two liters. LPM #6 was asked how facility staff ensures residents' care plans are followed. LPN #6 stated the CNAs had cards to follow and nurses could look at the care plans in the computer.

On 3/8/17 at 11:50 a.m., an interview was conducted with LPN #1. LPN #1 was asked how facility staff ensures residents' care plans are followed. LPN #1 stated care plan information was relayed to nurses and CNAs during shift change report, nurses could look at the care plans and CNAs had care cards (note- Resident #12's care card (no date) documented, "Resident is A&O (alert and oriented)- 02 (oxygen) 2l/min (liters per minute) PRN (as needed)..."

On 3/8/17 at 5:00 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern.

The facility policy titled, "Oxygen Administration' documented, "1. Check physician's order for liter flow and method of administration...6. Nasal Cannula: Connect tubing to humidifier outlet and adjust liter flow as ordered..."

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The oxygen concentrator operator's manual documented, "Note: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min. (liter per minute) line prescribed..."

No further information was presented prior to exit.

b. The facility staff failed to follow Resident #12's written plan of care for the monitoring of fluid restriction.

Review of Resident #12's most recent physician's order summary signed by the physician on 1/29/17 documented, "1.5L (liters) fluid restriction every shift related to HEART FAILURE..."

Resident #12's comprehensive care plan initiated on 4/12/16 documented, "Alteration in Respiratory Status r/t (related to) Dx (diagnosis) of COPD (chronic obstructive pulmonary disease)...Interventions: Diet and fluid restriction as ordered by Physician..."

Resident #12's January 2017 and February 2017 MARs (medication administration records) documented, "1.5L fluid restriction every shift related to HEART FAILURE...1260cc (cubic centimeters) from dietary 240cc from nursing..." The MARs documented an allowance of 480cc for day shift, 360cc for evening shift and 360cc for night shift. Resident #12's March 2017 MAR documented, "1.5L fluid restriction every shift related to HEART FAILURE...1260cc from dietary 240cc from nursing..." The MAR failed to document a fluid allowance for each nursing shift

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to evidence each shift monitored/communicated how much fluid was administered.

On 3/8/17 at 11:28 a.m., an interview was conducted with LPN (licensed practical nurse) #6 regarding the facility process for the documentation and monitoring of fluid restriction. LPN #6 stated the dietary department gave residents with fluid restrictions a certain amount of fluids and then the nursing department was allowed to give residents a certain amount each shift. LPN #6 stated each nursing shift documented how much fluid was given to the residents on fluid restrictions. LPN #6 was asked to look at Resident #12's March 2017 MAR. This surveyor asked LPN #6 if the process was for each nursing shift to document how much fluid was given to the resident each shift. LPN #6 stated she gives Resident #12 60cc of fluid in the mornings and the resident receives fluids on her lunch tray. LPN #6 stated Resident #12 is non-compliant with fluid restrictions when she goes out of the facility (note- review of the resident's progress notes revealed the resident was non-compliant with fluid restriction). LPN #6 confirmed she didn't see fluid intake documentation for each shift on Resident #12's March 2017 MAR. LPN #6 was asked how the resident's fluid intake/restriction was monitored each shift and how nursing staff communicated the resident's fluid intake each shift. LPN #6 stated, "Usually when we give report, we go through that." LPN #6 stated she didn't know if all nurses report the resident's fluid intake during shift change report and confirmed she didn't see documentation of Resident #12's fluid intake for each shift on the March 2017 MAR. LPN #6 was asked how facility staff ensures residents' care plans are followed. LPN #6 stated the CNAs had

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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cards to follow and nurses could look at the care plan in the computer.

On 3/8/17 at 11:50 a.m., an interview was conducted with LPN #1 (unit manager) regarding the facility process for the documentation and monitoring of fluid restriction. LPN #1 stated the amount of fluid to be given to each resident on fluid restriction is different and is broken down between how much fluids are served on meal trays and how much should be given by nurses. LPN #1 stated each nurse has to calculate the amount of fluid given during medication administration and the nurse must include supplements that are administered. LPN #1 stated nurses document the amount of fluid given each shift on the MAR. LPN #1 was asked how each nurse knows how much fluid has been given during the previous shift and how much fluid can be given during their shift. LPN #1 stated, "The only thing I can say is they tell each other." LPN #1 stated she could not confirm every nurse did so. LPN #1 was asked how facility staff ensures residents' care plans are followed. LPN #1 stated care plan information is relayed to nurses and CNAs during shift change report, nurses can look at the care plans and CNAs have care cards (note- Resident #12's care card (no date) documented, "1500cc fluid restriction..."

On 3/8/17 at 5:00 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. A policy regarding fluid restriction and following care plans was requested.

On 3/9/17 at 11:36 a.m., ASM #1 stated the facility staff had exhausted all of their efforts to locate the requested policies.

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F 282	Continued From page 49 No further information was presented prior to exit.	F 282	F309 1. Resident #12 fluid restriction order has been revised on the EMAR to include the amount of fluid per shift. 2. A review of residents on fluid restrictions was conducted to ensure the amount of fluid per shift is on the EMAR. 3. Licensed staff will be re-educated on the appropriate procedure to input fluid restriction as ordered by the physician on the EMAR. 4. Audits of residents who have fluid restriction orders will be conducted weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 4/7/17	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain a resident's highest level of well-being for one of 29 residents in the survey sample, Resident #12. The facility staff failed to monitor Resident #12's	F 309		

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physician ordered fluid restriction during March 2017.

The findings include:

Resident #12 was admitted to the facility on 2/2/16. Resident #12's diagnoses included but were not limited to: heart failure, diabetes and chronic obstructive pulmonary (respiratory) disease. Resident #12's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 1/17/17, coded the resident's cognition as severely impaired. Section G coded Resident #12 as being independent with setup help only with transfers and locomotion.

Review of Resident #12's most recent physician's order summary signed by the physician on 1/29/17 documented, "1.5L (liters) fluid restriction every shift related to HEART FAILURE..."

Resident #12's comprehensive care plan initiated on 4/12/16 documented, "Alteration in Respiratory Status r/t (related to) Dx (diagnosis) of COPD (chronic obstructive pulmonary disease)...Interventions: Diet and fluid restriction as ordered by Physician..."

Resident #12's January 2017 and February 2017 MARs (medication administration records) documented, "1.5L fluid restriction every shift related to HEART FAILURE...1260cc (cubic centimeters) from dietary 240cc from nursing..." The MARs documented an allowance of 480cc for day shift, 360cc for evening shift and 360cc for night shift. Resident #12's March 2017 MAR documented, "1.5L fluid restriction every shift related to HEART FAILURE...1260cc from dietary

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240cc from nursing..." The MAR failed to document a fluid allowance for each nursing shift to evidence each shift monitored/communicated how much fluid was being administered.

On 3/8/17 at 11:28 a.m., an interview was conducted with LPN (licensed practical nurse) #6 regarding the facility process for the documentation and monitoring of fluid restriction. LPN #6 stated the dietary department gave residents with fluid restrictions a certain amount of fluids and then the nursing department was allowed to give residents a certain amount each shift. LPN #6 stated each nursing shift documented how much fluid was given to the residents on fluid restrictions. LPN #6 was asked to look at Resident #12's March 2017 MAR. This surveyor asked LPN #6 if the process was for each nursing shift to document how much fluid was given to the resident each shift. LPN #6 stated she gives Resident #12 60cc (cubic centimeters) of fluid in the mornings and the resident receives fluids on her lunch tray. LPN #6 stated Resident #12 is non-compliant with fluid restrictions when she goes out of the facility (note- review of the resident's progress notes revealed the resident was non-compliant with fluid restriction). LPN #6 confirmed she didn't see fluid intake documentation for each shift on Resident #12's March 2017 MAR. LPN #6 was asked how the resident's fluid intake/restriction was monitored each shift and how nursing staff communicated the resident's fluid intake each shift. LPN #6 stated, "Usually when we give report, we go through that." LPN #6 stated she didn't know if all nurses report the resident's fluid intake during shift change report and confirmed she didn't see documentation of Resident #12's fluid intake for each shift on the March 2017

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F 309	Continued From page 52 MAR. On 3/8/17 at 11:50 a.m., an interview was conducted with LPN #1 (unit manager) regarding the facility process for the documentation and monitoring of fluid restriction. LPN #1 stated the amount of fluid to be given to each resident on fluid restriction is different and is broken down between how much fluids are served on meal trays and how much should be given by nurses. LPN #1 stated each nurse has to calculate the amount of fluid given during medication administration and the nurse must include supplements that are administered. LPN #1 stated nurses document the amount of fluid given each shift on the MAR. LPN #1 was asked how each nurse knows how much fluid has been given during the previous shift and how much fluid can be given during their shift. LPN #1 stated, "The only thing I can say is they tell each other." LPN #1 stated she could not confirm every nurse did so. On 3/8/17 at 5:00 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. A policy regarding fluid restriction was requested. On 3/9/17 at 11:36 a.m., ASM #1 stated the facility staff had exhausted all of their efforts to locate the requested policy. No further information was presented prior to exit.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity -	F 314		

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F 314	Continued From page 53 (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation staff interview and clinical record review it was determined the facility staff failed to provide wound care care, consistent with professional standards of practice, to prevent pressure ulcers and in a manner to promote healing and prevent infection of a pressure sore for one of 29 residents in the survey sample, Resident #3. The wound nurse, LPN (licensed practical nurse) #3, did not clean her scissors prior to using them during a dressing change for Resident #3. The findings include: Resident #3 was admitted to the facility on 2/7/17 with diagnoses that included but were not limited to: dementia, deep vein thrombosis (blood blot), seizures, depression, vitamin D deficiency, and gastroesophageal reflux disease.	F 314	F314 1. Infection control practices are being followed for resident #3 wound treatments. 2. Residents receiving wound care treatments have the potential of being affected. 3. Licensed staff will be re-educated on infection control techniques for wound care. The staff performing wound care treatments will be observed randomly to ensure proper infection control techniques are being followed during treatments. 4. Observations of wound care treatments will be conducted weekly for four weeks then monthly for three months. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 4/7/17	

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The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 2/14/17, coded the resident as being severely impaired to make daily cognitive decisions. The resident was coded as being dependent or requiring extensive assistance with all of her activities of daily living.

The physician orders dated, 1/31/17, documented, "Cleanse right lateral ankle wound with wound cleanser, apply Santyl, cover with calcium alginate and dry dressing QD (every day), every day shift."

The most recent wound doctor notes dated, 2/28/17, documented Resident #3 had a right later ankle wound, that was a Stage IV (four) Pressure sore (1) measuring 2.3 cm. (centimeters) by 1.9 cm. by 0.1 depth. It was documented as having 100% granulation tissue present.

On 3/8/17 at 10:55 a.m., LPN (licensed practical nurse) #3, the wound nurse was observed providing wound care to Resident #3. LPN #3 gathered her supplies and placed them on the treatment cart. LPN #3 pulled her scissors out of her pocket and cut a piece of white adhesive tape. She was not observed cleaning the scissors. When asked if she cleaned her scissors, LPN #3 stated, "No, I didn't." LPN #3 was asked when scissors should be cleaned. LPN #3 stated, "Before I cut anything for a dressing change." When asked what was in the pocket she had removed the scissors from, LPN #3 reached into her pocket and showed this surveyor a pen and keys. LPN #3 proceeded to

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provide the dressing change to Resident #3 using the tape cut with the scissors she had not cleaned.

On 3/8/17 at 11:20 a.m., during the wound care, RN (registered nurse) #1, the assistant director of nursing, came to assist LPN #3 with the dressing change. RN #1 was asked when a nurse should clean her scissors. RN #1 stated, "Before and after each use." LPN#3 completed the remainder of the dressing change using good technique.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/8/17 at 2:08 p.m., regarding when staff should clean scissors being used for dressing changes. ASM #2 stated, "Before you cut anything." A policy was requested on dressing changes and cleaning of the scissors. ASM #2 was made aware of the concern.

The administrator was made aware of the above findings on 3/8/17 at 5:15 p.m.

On 3/9/17 at 10:45 a.m. ASM #2 informed this surveyor that the facility did not have a policy on dressing changes.

In a study conducted by the International Conference on Nosocomial and Healthcare related Infections in Atlanta Georgia, March 2000 showed that ordinary items can make your patients sick.
In one study, a researcher gathered scissors that nurses and physicians kept in their pockets, as well as communal scissors left on dressing carts and tables. Three-quarters of the scissors carried microorganisms, including Staphylococcus aureus, Groups A and B streptococcus, and

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F 314	Continued From page 56 gram-negative bacilli. The solution is quite simple. If health care workers swab the scissors with alcohol after each use, they will virtually eliminate the risk of transmission of microorganisms. In the study, contaminated scissors were effectively disinfected after swabbing the scissors with alcohol. Reference: Embil JM, Dyck B, McLeod J, et al. Scissors as a potential source of nosocomial infection? Presented at the 4th Decennial International Conference on Nosocomial and Healthcare-Associated Infections. Atlanta; March 8, 2000 No further information was provided prior to exit. (1) Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -	F 323		

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F 323	Continued From page 57 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain a safe and hazard free environment in one of 92 resident bathrooms and one of six medication carts. The facility staff failed to address steel bolts, approximately a half inch diameter that protruded from Resident #11's bathroom floor beside the commode above the level of the tile floor and in the direct path of Resident #11 when moving between the commode and the sink.	F 323	F323 1. Resident #11 bathroom was repaired by covering the tile floor with LVT such that there is a smooth surface. The handrails were secured. 2. Each resident room bathroom has the potential of being affected. 3. Each resident room bathroom was reviewed by maintenance staff on 3/8. Any floor found to be noncompliant was repaired by placing LVT over the floor tile to ensure a smooth surface throughout the bathroom. Cove base was replaced as needed. Hand rails were secured as identified. Each maintenance staff will be assigned a unit which they will be responsible for. A resident room maintenance checklist was implemented which identifies areas in the resident room and resident room bathroom to observe. Each room will be reviewed monthly.	

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F 323	Continued From page 58 The findings include: Resident #11 was admitted to the facility on 12/4/16 with diagnoses that included, but were not limited to, dementia, high blood pressure, a history of rectal prolapse and heart failure. Resident #11's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/10/16, coded Resident #11 as having a BIMS (brief interview of mental status) score of seven out of a possible score of 15, indicating that Resident #11 is cognitively severely impaired. Resident #11 was also coded as requiring supervision and assistance of one person for personal hygiene and extensive assistance of two people for toileting. On 3/17/17 at 11:45 a.m. an observation was made of Resident #11 sitting on the edge of her bed in her room. An inspection was made at this time of her bathroom, shared by Resident #11 and her roommate. On the tiled floor of the bathroom were six areas, approximately 3 - 5" in diameter, with missing tiles and a gray, concrete type material that had been placed over these areas. Further inspection revealed that in the center of each of these areas there was a steel bolt protruding from the concrete substance; the steel bolt was slightly above the level of the tile, the bolts were not flush to the surface. This surveyor moved her foot over the areas to confirm that the steel bolts were not flush. The six areas were spaced around the front of the commode. Two of the areas were in the direct path between the commode and the sink causing a hazard to anyone who used the bathroom and did not wear shoes.	F 323	4. In addition to the maintenance checklist, care keeper round sheets will be submitted to the Administrator daily for review and follow up. Results will be reviewed at the monthly QAPI meeting to ensure compliance. 5. Compliance Date: 4/7/17	

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On 3/8/17 at 10:20 a.m. Resident #11 was observed walking around her bathroom and at the sink washing her hands. Resident #11 was wearing shoes and was performing personal care independently.

On 3/8/17 at 2:40 p.m. ASM (administrative staff member) #2, the director of nursing and OSM (other staff member) #2 were asked to inspect Resident #11's bathroom with this surveyor. OSM #2 was asked about the bolts that were sticking up above the tile surface on the floor. OSM #2 stated that they were from when the handrails were secured to the floor; they had been removed "a long time ago." OSM #2 inspected the areas of concern and stated, "These are not safe the way they are sticking out of the floor." OSM #2 and this surveyor ran our hands over the bolt that was closest to the sink and OSM #2 acknowledged that the bolt was sharp and that it was located where the resident would stand when moving between the commode and sink. OSM #2 stated that he would fix the situation immediately.

On 3/8/17 at 5:00 p.m. a meeting was held with ASM #1, the administrator. ASM #1 was made aware of the above findings. A policy regarding maintenance / safety of resident bathrooms was requested.

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

F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(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 328	Continued From page 60 (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure	F 328	F328 1. Resident #12 is receiving oxygen per physician order. 2. A review of residents utilizing oxygen concentrators was conducted to ensure the concentrator was set at ordered liters. 3. License staff will be re-educated on the oxygen therapy policy. 4. A review of residents who use oxygen concentrators will be conducted weekly for four weeks then monthly times three. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 4/7/17	

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that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide respiratory care services for one of 29 residents in the survey sample, Resident #12.

The facility staff failed to administer oxygen to Resident #12 per physician's order.

The findings include:

Resident #12 was admitted to the facility on 2/2/16. Resident #12's diagnoses included but were not limited to: heart failure, diabetes and chronic obstructive pulmonary (respiratory) disease. Resident #12's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 1/17/17, coded the resident's cognition as severely impaired. Section G coded Resident #12 as being independent with setup help only with

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transfers and locomotion.

Review of Resident #12's clinical record revealed a physician's order summary signed by the physician on 1/29/17 that documented an order for oxygen at two liters per minute via nasal cannula for shortness of breath as needed.

Resident #12's comprehensive care plan initiated on 4/12/16 documented, "Alteration in Respiratory Status r/t (related to) Dx (diagnosis) of COPD (chronic obstructive pulmonary disease)...Interventions: Administer oxygen as needed per Physician order..."

On 3/7/17 at 1:30 p.m., observation of Resident #12 was conducted. The resident's oxygen tubing was sitting on the bed while the resident placed lotion on her hands. When asked if she wears her oxygen all the time, Resident #12 stated she was about to put her oxygen back on and placed the nasal cannula back on her face. The ball in the oxygen concentrator flowmeter was observed positioned between the line for one and a half liters and the line for two liters. When asked if she ever adjusts the flowmeter knob on the oxygen concentrator, Resident #12 stated she did not.

On 3/7/17 at 3:35 p.m., Resident #12 was observed wearing the oxygen nasal cannula. The ball in the oxygen concentrator flowmeter was positioned between the line for one and a half liters and the line for two liters.

On 3/8/17 at 11:25 a.m., Resident #12 was observed wearing the oxygen nasal cannula. The ball in the oxygen concentrator flowmeter was positioned between the line for one and a half

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liters and the line for two liters. This observation was confirmed by another surveyor.

On 3/8/17 at 11:28 a.m., an interview was conducted with LPN (licensed practical nurse) #6 (the nurse caring for Resident #12). LPN #6 was asked to describe where the ball in the oxygen concentrator flowmeter should be located if a resident has a physician's order for two liters; LPN #6 looked at another resident's oxygen concentrator and stated the middle of the ball should be at the two liter line. LPN #6 stated Resident #12 knew how to turn her concentrator on and off but she (LPN #6) had not ever seen the resident adjust the flowmeter knob. LPN #6 stated she checks the resident's concentrator once a day to make sure the flowmeter is set at the prescribed rate of two liters. When shown Resident #12's oxygen concentrator, LPN #6 stated, "To me it's on two liters but the ball needs to go up a little bit." LPN #6 adjusted the flowmeter knob so that the middle of the ball was resting on the two liter line. LPN #6 stated the flowmeter ball wasn't completely on two liters and wasn't completely off two liters. LPM #6 was asked how facility staff ensures residents' care plans are followed. LPN #6 stated the CNAs had cards to follow and nurses could look at the care plans in the computer.

On 3/8/17 at 11:50 a.m., an interview was conducted with LPN #1. LPN #1 was asked how facility staff ensures residents' care plans are followed. LPN #1 stated care plan information was relayed to nurses and CNAs during shift change report, nurses could look at the care plans and CNAs had care cards (note- Resident #12's care card (no date) documented, "Resident is A&O (alert and oriented)- 02 (oxygen) 2l/min

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F 328	Continued From page 64 (liters per minute) PRN (as needed)..." On 3/8/17 at 5:00 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, "Oxygen Administration' documented, "1. Check physician's order for liter flow and method of administration...6. Nasal Cannula: Connect tubing to humidifier outlet and adjust liter flow as ordered..." The oxygen concentrator operator's manual documented, "Note: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min. (liter per minute) line prescribed..." No further information was presented prior to exit. According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."	F 328		
F 354 SS=D	483.35(b)(1)-(3) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON (1) Except when waived under paragraph (e) or (f) of this section, the facility must use the	F 354		

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F 354	Continued From page 65 services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. (2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to maintain RN (registered nurse) coverage for eight consecutive hours each day. The facility staff failed to utilize the services of a RN for eight consecutive hours on Saturday 2/25/17 and Sunday 2/26/17. The findings include: On 3/7/17 at 4:30 p.m., review of daily assignment sheets with ASM (administrative staff member) #2 (the director of nursing) revealed no RN coverage on 2/25/17 and 2/26/17. ASM #2 stated she or the assistant director of nursing may have been in the building those days. ASM #2 was asked to present time cards for any RN who was in the building on those days. On 3/8/17 at 10:05 a.m., ASM #2 presented a time card for RN #3 (MDS coordinator). The time card documented RN #3 was present in the building on 2/25/17 for 5.45 hours and on 2/26/17 for 4.1 hours. ASM #2 stated the assistant director of nursing was present in the building on	F 354	F354 1. There is RN coverage 7 days a week for 8 hours per day. 2. The Director of Nursing Services (DNS) will complete a daily review to ensure appropriate RN coverage. 3. In-servicing appropriate staff to contact the DNS when an RN calls in. The staffing coordinator will be in-serviced to ensure an RN is scheduled 7 days a week for 8 hours per day. 4. An audit sheet will be submitted at the QAPI meeting weekly for four weeks then monthly for three months to ensure compliance. 5. Compliance Date: 4/7/17	

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F 354	Continued From page 66 2/25/17 and she (ASM #2) was in the building on 2/26/17 but neither of them utilized the time clock so she could not provide evidence that either of them were in the building on those days. On 3/8/17 at 10:15 a.m., an interview was conducted with CNA (certified nursing assistant) #5 (the staffing coordinator). CNA #5 stated the facility utilized a RN for eight hours on all shifts. CNA #5 stated the facility employed a RN unit manager, a 3:00 p.m. to 11:00 p.m. RN supervisor and an 11:00 p.m. to 7:00 a.m. RN supervisor. When asked if a RN was utilized for eight hours on the weekends, CNA stated the facility was currently hiring for registered nurses and was looking for a weekend RN supervisor. On 3/8/17 at 5:00 p.m., ASM #1 (the administrator) was made aware of the above concern and the facility policy was requested. On 3/9/17 at 11:36 a.m., ASM #1 stated the facility staff had exhausted all of their efforts to locate the requested policy. No further information was present prior to exit.	F 354		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (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	F 371		

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F 371	Continued From page 67 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. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to, store and prepare food in a sanitary manner. The findings include: On 3/7/17 at approximately 11:10 a.m., a tour of the kitchen was conducted with the dietary manager, OSM #11 (Other Staff Member). The following items were observed: - A large (multiple quarts sized) metal pot which had approximately 1/4 to 1/2 inch of water in the bottom, was observed on a storage rack of clean items ready for use. - A stack of 25 large size steam table pans were observed on another storage rack of clean items ready for use. The lip of the pans had a greasy residue around the bottom side.	F 371	F371 1. The metal pot was removed from the storage rack. The baking sheet pans and steam table pans were cleaned on 3/9/17. The food scale on the prep table was cleaned. The slicer was removed from the kitchen. Refrigerated/freezer items were wrapped and dated properly. The box on the stock room floor was stored correctly. Additional vegetables were ordered. 2. Each resident has the potential of being affected. 3. Kitchen staff were in-serviced on the cleaning schedule policy and the proper storage and labeling of items that are to be stored in the refrigerator or freezer. The assistant manager was in-serviced on how to order food based on established par levels. A daily compliance checklist was implemented to	

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F 371	Continued From page 68 - 17 large sized baking sheets were observed stored on a cart. Nine of these sheets had significant amount of dried black crusty residue around the lip of the pans. - A food scale covered in dried food residue was observed on a prep table. - A meat slicer that was stored covered and ready for use was observed with dried residue in the grooves of the support rack. - In a storage refrigerator, an opened package of cheese slices was dated 3/1/17. The back was not sealed, exposing the cheese to the environment. - Also in a storage refrigerator, a pan of cooked BBQ chicken was only loosely covered in plastic wrap, exposing the chicken to the environment. - An upper and lower convection oven had dried black residue all in both sections of the oven. - In a dry storage pantry area, a box of 192 count fudge rounds was observed stored directly on the floor. Throughout the tour, OSM #11, dietary manager, made note of the items and stated that these items should not be this way. On 3/7/17 at 11:35 a.m., policies addressing these concerns were requested from OSM #11. The policies that were provided documented the following: A policy on "Food Storage - Dry Goods" documented, "1. The Food Services Director or	F 371	ensure cleanliness throughout the kitchen. 4.Tray line audits will be randomly conducted 8 times each week to ensure the menu is being followed and appropriate portions are prepared. The items stored in the refrigerator/freezer will be reviewed 10 times each week to ensure proper storage and labeling. The audits will be completed by the Food Service Director or Assistant Director. Weekly follow ups will be completed by the District or Regional Manager. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance. 5. Compliance Date: 4/7/17	

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designee is responsible to store all items 6 inches above the floor on shelves, racks, dollies, or other surfaces which facilitate thorough cleaning."

A policy on "Food Storage: Cold" documented, "5. The Food Services Director / Cook(s) insures that all food items are stored properly in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination."

A policy on "Equipment" documented, "1. The Food Services Director will ensure that all equipment is routinely cleaned and maintained in accordance to manufacturer directions and training materials. 2. The Food Service Director will ensure that all staff members are properly trained in the cleaning and maintenance of all equipment. 3. The Food Services Director ensures that all food contact equipment is cleaned and sanitized after every use. 4. The Food Services Director ensures that all non-food contact equipment is clean." A page from the FDA Food Code provided by the facility documented, "3-305.11 Food Storage....Food shall be protected from contamination by storing the food: (1) in a clean, dry location (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (centimeters) (6 inches) above the floor."

No further information was provided by the end of the survey.

According to the Federal Food Code:

3-202.15 Package Integrity.
FOOD packages shall be in good condition and protect the integrity of the contents so that the FOOD is not exposed to ADULTERATION or

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F 371	Continued From page 70 potential contaminants. 3-305.11 Food Storage. 1. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: 1. (1) In a clean, dry location; 2. (2) Where it is not exposed to splash, dust, or other contamination; and 3. (3) At least 15 cm (6 inches) above the floor. 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. Pf (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.	F 371		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 431		

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F 431	Continued From page 71 (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 431	F431 1. Medication carts are being locked when unattended. 2. Observation audits will be conducted on all licensed staff to ensure medication carts are locked according to policy. 3. Licensed staff will be re-educated on the policy regarding the locking of medication carts when unattended. 4. Audits of staff during medication administration will be conducted weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 4/7/17	

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Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure safe supervision of medications during the Medication Pour and Pass observation on one of three wings (Wing C).

During a medication pour and pass observation in Wing C, RN (Registered nurse) #5 failed to lock the medication cart prior to entering a resident's room. The medication cart was out of RN #5's line of sight and a resident was observed approximately five feet away from the cart.

The findings include:

On 3/7/17 at 5:00 p.m., during the medication administration observation, RN #5 was observed preparing Resident #17's medications at the medication cart in the hall. RN #5 locked the cart and entered the resident's room. While in Resident #17's room, RN #5 stated she needed to retrieve another glucometer strip (used to test residents' blood sugar). RN #5 exited Resident #17's room and retrieved glucometer strips from the medication cart. RN #5 failed to lock the medication cart prior to re-entering Resident #17's room. The medication cart remained unlocked and out of RN #5's line of sight while she was in Resident #17's room; another resident was observed in a wheelchair approximately five feet away from the medication cart. After medication administration, RN #5 exited Resident #17's room and returned to the medication cart. At this time, RN #5 was asked if the cart was locked or unlocked. RN #5 pulled open a drawer in the medication cart (without having to unlock the cart) and stated, "I'm sorry." RN #5 confirmed

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F 431	Continued From page 73 the medication cart should be locked when she is not present. On 3/8/17 at 5:00 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, "Medication Administration- General Guidelines" documented, "During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide..." Resident #17 was admitted to the facility on 2/7/17. Resident #17's diagnoses included but were not limited to: high blood pressure, diabetes and major depressive disorder. Resident #17's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/14/17, coded the resident as being cognitively intact. No further information was presented prior to exit.	F 431		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 441		

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F 441	Continued From page 74 conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 441	F441 1. A) The infection control logs are complete and current. B) Hand washing procedures are being followed. C) Medication administration procedures are being followed by licensed staff for residents. D) Infection control practices are being followed during wound treatments. Proper hand hygiene is being done prior to resident #18 receiving their medications. Resident #19 is receiving their medication according to proper medication administration standards. Resident #3 is receiving their wound care according to proper infection control standards. 2. A) A review of new antibiotic orders in the last 30 days will be completed to ensure accuracy and proper documentation is made in the infection control logs. B) Licensed staff will be observed during medication administration for proper hand washing procedure. C) Licensed staff will be observed during medication administration that	

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(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined facility staff failed to maintain a complete infection control program as evidenced by incomplete infection control tracking logs for December 2016 and January 2017; and the facility failed to maintain infection control practices during medication administration for two of five residents, Resident #18 and Resident #19; and failed to maintain infection control practices during a dressing chnage for one of 29 residents in the survey sample, Resident #3.

1. The facility staff failed to maintain a complete infection control log as evidenced by no documented evidence regarding the result of the organism found in the cultures obtained during December 2016 and January 2017.

2. RN (Registered nurse) #5 failed to perform hand hygiene prior to administering medications to Resident #18.

3. LPN (Licensed practical nurse) #6 administered a pill to Resident #19 after touching

proper procedures are being followed. D) Observation reviews of staff performing wound care treatments will be conducted to ensure proper infection control technique is being followed.

3. A) Licensed staff will be re-educated on proper infection control techniques during wound care. B) Licensed staff will be re-educated on proper hand washing procedure during medication administration. C) Licensed staff will be re-educated on proper medication administration procedures. D) Licensed will be re-educated on proper infection control technique during wound care.

4. A) Audits of the Infection control logs, B) reviews of hand washing procedure during medication administration, C) medication administration procedures and D) wound care treatments will be conducted weekly for four weeks then monthly for three weeks.

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F 441	Continued From page 76 the pill with her bare hand. 4. The facility staff failed to maintain infection control practices during a dressing change for Resident #3. The findings include: 1. Review of the infection control logs from the previous survey in March 2016 was completed and revealed the following: - On the December 2016 log there were nine urine cultures documented as being completed. There was no documented evidence regarding the result of the organism found in the cultures. - On the January 2017 log there were 13 urine cultures and three wound cultures documented as being taken. There was no documented evidence regarding regarding the result of the organism found in the cultures. An interview was conducted on 3/8/17 at 2:15 p.m. with RN (registered nurse) #1, the assistant director of nursing who is responsible for the infection control program. When asked why infections were tracked and trended, RN #1 stated, "To make sure the antibiotic is susceptible to the organism."" When asked where the results of the cultures were for the items identified above on the infection control logs, RN #1 stated, "I looked at them but I didn't document it." When asked if the results should be documented, RN #1 stated, "I know I should be putting the c&s (culture and sensitivity) results on the logs. It's my oversight." On 3/8/17 at 5:00 p.m. ASM (administrative staff	F 441	Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 4/7/17	

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member) #1, the administrator was made aware of the findings.

Review of the facility's policy titled, "Infection Control Surveillance" initiated in February 2017 documented, "PROCEDURE: The Infection Control Committee (ICC) directs the infection control program and maintains minutes of all activities. The scope of surveillance includes: A. Establishing baseline nosocomial (1) infection rates. B. Review of microbiological reports. C. Review of resident infections to determine whether an infection is nosocomial using the CDC (centers for disease control) guidelines. D. Review and analysis of surveillance data to include: Infections due to unusual pathogens. Clusters of infections. Unusual epidemics. Nosocomial infection rate exceeds the baseline..." There was no specific documentation regarding documentation on the infection control log but the new log had a column titled, "ORGANISM CULTURED."

No further information was provided prior to exit.

(1) Nosocomial -- A nosocomial infection is contracted because of an infection or toxin that exists in a certain location, such as a hospital. This information was obtained from: http://www.healthline.com/health/hospital-acquired-nosocomial-infections#Overview1

2. RN (Registered nurse) #5 failed to perform hand hygiene prior to administering medications to Resident #18.

Resident #18 was admitted to the facility on 2/17/17. Resident #18's diagnoses included but were not limited to: fractured right arm, high blood pressure and diabetes. Resident #18's

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F 441	Continued From page 78 admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/24/17 was in progress; however, section C was completed and coded the resident as being cognitively intact. On 3/7/17 at 5:00 p.m., during the medication administration observation, RN #5 was observed administering medications to another resident. After administration to that resident, RN #5 returned to the medication cart, prepared Resident #18's medications and administered the medications to Resident #18 without performing hand hygiene (hand washing or hand sanitizer). While administering medications to Resident #18, RN #5 was observed placing the medication cup to the resident's mouth for the resident to swallow the pills. On 3/7/17 at 5:20 p.m., an interview was conducted with RN #5. RN #5 was asked what should be done in between medication administration to each resident and why. RN #5 stated hand sanitizer should be used so she didn't transfer "something" from one person to the next. At this time RN #5 confirmed she did not perform hand hygiene prior to administering medication to Resident #18 and was then observed placing hand sanitizer on her hands. On 3/8/17 at 5:00 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, "Medication Administration- General Guidelines" documented, "2. Handwashing and Hand Sanitization: The person administering medications adheres to good hand hygiene, which includes washing	F 441		

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hands thoroughly
before beginning a medication pass
prior to handling any medication
after coming into direct contact with a resident,
before and after administration of ophthalmic, topical, vaginal, rectal, and parenteral preparations, and
before and after administration of medications via enteral tubes...
b. Hand sanitization is done with an approved sanitizer
between handwashings, when returning to the medication cart or preparation area (assuming hands have not touched a resident or potentially contaminated surface).
at regular intervals during the medication pass such as after each room, again assuming handwashing is not indicated..."

No further information was presented prior to exit.

3. LPN (Licensed practical nurse) #6 administered a pill to Resident #19 after touching the pill with her bare hand.

Resident #19 was admitted to the facility on 10/29/10. Resident #19's diagnoses included but were not limited to: diabetes, high blood pressure and incontinence. Resident #19's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/26/16, coded the resident as being cognitively intact.

On 3/8/17 at 8:07 a.m., during the medication administration observation, LPN #6 was observed administering medications to Resident #19. Resident #19 placed the medication cup of pills to

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her mouth and a pill dropped out of the cup onto the resident's gown covering the resident's chest. LPN #6 picked the pill up with her bare hand, placed the pill into the medication cup and handed the cup to the resident; Resident #19 ingested the pill.

On 3/8/17 at 8:19 a.m., an interview was conducted with LPN #6 regarding the above observation. LPN #6 stated the pill should have been picked up with a glove because the resident didn't need to be contaminated by what was on her (LPN #6's) hand.

On 3/8/17 at 10:18 a.m., ASM (administrative staff member) #2 (the director of nursing) presented an in-service dated 3/8/17 and signed by LPN #6. The in-service documented, "When passing medications ensure to follow protocols. Do Not touch any meds (medications) with bare hands- retrieve another pill if one is dropped."

On 3/8/17 at 5:00 p.m., ASM #1 (the administrator) was made aware of the above concern.

The facility policy titled, "Medication Administration- General Guidelines" failed to address what a nurse should do if a pill is dropped.

No further information was presented prior to exit.

4. The facility staff failed to maintain infection control practices during a dressing change for Resident #3.

Resident #3 was admitted to the facility on 2/7/17

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with diagnoses that included but were not limited to: dementia, deep vein thrombosis (blood blot), seizures, depression, vitamin D deficiency, and gastroesophageal reflux disease.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 2/14/17, coded the resident as being severely impaired to make daily cognitive decisions. The resident was coded as being dependent or requiring extensive assistance with all of her activities of daily living.

On 3/8/17 at 10:55 a.m. LPN (licensed practical nurse) #3, the wound nurse, was observed providing wound care to Resident #3. LPN #3 gathered her supplies and placed them on the treatment cart. LPN #3 pulled her scissors out of her pocket and cut a piece of white adhesive tape. She was not observed cleaning the scissors. When asked if she cleaned her scissors, LPN #3 stated, "No, I didn't." LPN #3 was asked when scissors should be cleaned. LPN #3 stated, "Before I cut anything for a dressing change." When asked what was in her pocket where the scissors were removed from, LPN #3 reached into her pocket and showed this surveyor a pen and keys. During the wound care, RN (registered nurse) #1, the assistant director of nursing, came to assist LPN #3 with the dressing change. RN #1 was asked when a nurse should clean her scissors. RN #1 stated, "Before and after each use."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/8/17 at 2:08 p.m. When asked when staff should clean scissors being used for dressing changes, ASM #2 stated, "Before you cut

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anything." A policy was requested on dressing changes and cleaning of the scissors. ASM #2 was made aware of the concern.

The administrator was made aware of the above findings on 3/8/17 at 5:15 p.m.

On 3/9/17 at 10:45 a.m. ASM #2 informed this surveyor that the facility did not have a policy on dressing changes.

In a study conducted by the International Conference on Nosocomial and Healthcare related Infections in Atlanta Georgia, March 2000 showed that ordinary items can make your patients sick.
In one study, a researcher gathered scissors that nurses and physicians kept in their pockets, as well as communal scissors left on dressing carts and tables. Three-quarters of the scissors carried microorganisms, including Staphylococcus aureus, Groups A and B streptococcus, and gram-negative bacilli. The solution is quite simple. If health care workers swab the scissors with alcohol after each use, they will virtually eliminate the risk of transmission of microorganisms. In the study, contaminated scissors were effectively disinfected after swabbing the scissors with alcohol.
Reference:
Embil JM, Dyck B, McLeod J, et al. Scissors as a potential source of nosocomial infection? Presented at the 4th Decennial International Conference on Nosocomial and Healthcare-Associated Infections. Atlanta; March 8, 2000

No further information was provided prior to exit.

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F 514 SS=D	Continued From page 83 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview,	F 514 F 514	F514 1. A) Non-pharmacological interventions are being documented prior to administrating prn pain medications for residents #10. B) Documentation has been completed for the pressure wound on resident #3. C) Blood pressure results are being documented for resident #6 on the EMAR. D) Resident #6 has her heel protectors on. 2. Each residents has the potential of being affected. 3. Licensed staff will be re-educated on the documentation policy regarding: A) using non-pharmacologic interventions prior to administering prn pain medication; B) the policy on proper documentation regarding pressure wounds; C) the policy on proper documentation regarding blood pressures; D) the policy on proper documentation for heel protectors.	

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clinical record review, and facility document review, it was determined that facility staff failed to maintain a complete and accurate clinical record for three of 29 residents in the survey sample, Resident #10, #3 and #6.

1. For Resident #10, facility staff failed to document non-pharmacological interventions attempted prior to the administration of prn (as needed) pain medication on several occasions in February and March of 2017.

2. The facility staff entered the staging of Resident #3's pressure sore into the initial note, three days after the initial note identifying the area was written and based the staging on an assessment completed three days after the area was found.

3a. The facility staff failed to document physician ordered blood pressures on the January and February medication administration records (MARs) for Resident #6.

b. The facility staff documented that Resident #6 had her heel protectors on when they were not.

The findings include:

1. Resident #10 was admitted to the facility on 6/22/16 with diagnoses that included but were not limited to Dementia with Lewy bodies [1], fracture of the right femur, type two diabetes, high blood pressure, and major depressive disorder. Resident #10's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 1/21/17. Resident #10 was coded as being cognitively intact in the ability to make daily decisions,

4. Audits will be conducted on the use of A)non-pharmacologic interventions prior to administering prn pain medication; B) pressure wound documentation; C) blood pressure documentation and D) heel protector documentation will be conducted weekly for four weeks then monthly for three months. Results will be reviewed at the monthly QAPI meeting for three months to ensure compliance.

5. Compliance Date: 4/7/17

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scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #10 was coded as requiring supervision only with transfers, dressing, eating, toileting, bathing, and bed mobility; and independent with locomotion.

Review of Resident #10's POS (physician order sheet) signed and dated 2/4/17 revealed the following order, "Percocet Tablet [2] 5-325 MG (milligrams) Give 1 tablet by mouth every 6 hours as needed for pain r/t (related to) fracture of tailbone related to FRACTURE OF COCCYX, INITIAL ENCOUNTER FOR CLOSED FRACTURE." This order was initiated on 12/5/16.

Review of Resident #10's February 2017 and March 2017 MARS (Medication Administration Record) documented the following order" "Percocet Tablet 5-325 MG (Oxycodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for pain r/t (related to) fracture of tailbone related to PAIN..." Further review of the MARS revealed that Resident #10 received Percocet 5/325 mg on the following dates:

2/5/17 at 10:37 p.m., 2/10/17 at 1:59 a.m., 2/15/17 at 6:32 p.m., 2/16/17 at 8:38 p.m., 2/17/17 at 9:37 p.m., 2/21/17 at 1:55 a.m., 2/23/17 at 6:04 p.m., 2/24/17 at 11:09 p.m., and 2/25/17 at 10:57 p.m., 3/4/17 at 1:29 a.m., 3/6/17 at 1:47 a.m. and 6:58 p.m., and 3/7/17 at 10:19 p.m.

Nursing notes could not be found documenting that non-pharmacological pain interventions were attempted prior to the administration of Percocet.

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On 3/8/17 at 10:20 a.m., an interview was conducted with Resident #10. Resident #10 stated that staff will attempt other things for her pain before they administer pain medication.

On 3/8/17 at 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) # 7. When asked about the process followed prior to administering PRN (as needed) pain medication, LPN #7 stated, "I would ask the resident to rate their pain, and where the pain is and then document." LPN #7 stated that she would attempt non-pharmacological interventions prior to administering medication such as massage and repositioning. When asked if she would document non-pharmacological interventions attempted, LPN #7 stated, "There is no place to document unless it's in a nursing note. We haven't really done that. We don't usually document."

On 3/8/17 at 10:42 a.m., an interview was conducted with LPN #9. When asked about the process followed prior to administering a PRN pain medication, LPN #9 stated that she would attempt non-pharmacological interventions first, but she would not document non-pharmacological interventions attempted. LPN #9 stated, "We don't really document interventions."

On 3/8/17 at 10:49 a.m., an interview was conducted with LPN #6. When asked the process followed prior to administering a PRN pain medication, LPN #6 stated that she would ask the resident their pain level using a pain scale from 1-10. LPN #6 stated that if the resident was not cognitively intact, she would look for non-verbal cues for pain such as grimacing. LPN #6 stated that she would try other interventions to relief pain

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prior to administering medication. LPN #6 stated that these interventions should be documented in the nursing notes.

On 3/8/17 at 10:50 a.m., an interview was conducted with LPN #11. LPN #11 stated she would assess a resident's pain by using the 1-10 scale and ask for the location of pain. LPN #11 stated that if a resident was not cognitively intact, she would assess for non-verbal cues for pain. LPN #11 stated that she would try interventions such as repositioning and distraction prior to administering pain medication. LPN #11 stated interventions should be documented in a nursing note.

On 3/8/17 at 5:20 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.

Potter-Perry contains a quotation on page 477 regarding documentation as follows: "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice."

[1] "-LBD is a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain. These deposits, called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement,

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behavior, and mood." This information was obtained from The National Institutes of Health. https://www.nia.nih.gov/alzheimers/publication/lewy-body-dementia/basics-lewy-body-dementia.

[2] -Narcotic pain reliever that treats moderate to severe pain. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011543/.

2. The facility staff entered the staging of Resident #3's pressure sore into the initial note, three days after the initial note identifying the area was written and based the staging on an assessment completed three days after the area was found.

Resident #3 was admitted to the facility on 2/7/17 with diagnoses that included but were not limited to: dementia, deep vein thrombosis (blood clot), seizures, depression, vitamin D deficiency, and gastroesophageal reflux disease.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 2/14/17, coded the resident as being severely impaired to make daily cognitive decisions. The resident was coded as being dependent or requiring extensive assistance with all of her activities of daily living.

The nurse's note dated, 2/5/17 at 11:43 p.m. documented, "7 pm (7:00 p.m.) called to room, CNA (certified nursing assistant) noted pinpoint area left buttocks, no drainage noted, MD (medical doctor) & RP (responsible party) notified, see treatment order 97.6 (temperature) -

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70 (pulse rate) - 18 (respiration rate) - 110/68 (blood pressure). Resident turned frequently."

The Pressure Ulcer Record documented, "Date first observed - 02/05/17. Site - Coccyx. Stage III (three). Size - pinpoint. Drainage - no. Odor - no." There was no signature of the nurse who completed this form.

Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (1)

The Pressure Ulcer Record documented:
"Date: 2/8 (2017)
Stage: 3
Length X width: 2 x 1.6
Depth: 0.1
Drainage: SS (serosanguinous)
Odor: (zero with a line through it indicating 'No')
Tunneling: (zero with a line through it indicating 'No')
Progress and or Remarks: New 80 G (granulation) 20 skin." These notes were documented by RN (registered nurse) #1.

An interview was conducted with RN #1, the assistant director of nursing, and LPN (licensed practical nurse) #2 on 3/8/17 at 10:40 a.m. The pressure ulcer record and the nurse's notes of

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2/5/17 were reviewed with RN #1 and LPN #2. When asked about staging a pinpoint area as a Stage 3 pressure ulcer, RN #1 stated, "I measured it on 2/8/17 and went back and put in the Stage III on the form based on what the (name of wound care doctor) assessed on 2/8/17." RN #1 was asked, if she had gone back and entered this for the 2/5/17 dated note and was asked if staff were allowed to go back and fill something in on a clinical record. RN #1 stated, "No, I guess not, I shouldn't have done that." RN #1 stated, "It was blank and I didn't think I could leave it blank." When asked if she had seen the wound on 2/5/17, RN #1 stated, "No." When asked if staff is allowed to backdate and fill in documents, RN #1 stated, "No, Ma'am."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/8/17 at 2:08 p.m. When asked if a nurse can go backwards and fill in blank on a form dated three days before, ASM #2 stated, "No." The pressure ulcer form and discussion with RN #1 was shared with ASM #2. A policy was requested on documentation.

The facility policy, "Pressure Ulcer Record Policy" documented in part, "Policy: To document the presence of skin impairment/new skin impairment related to Pressure when first observed and weekly thereafter. Procedure: 1. Residents have a Pressure Ulcer Record completed for each skin impairment that is related to Pressure. 2. Mark the pressure area on the body description identifying the site. 3. Enter the date first observed. 4. Enter the stage of the pressure ulcer. 5. Enter the size of the pressure ulcer - length x width x depth in centimeters. 6. Enter the

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granulation of the ulcer. &. Enter the drainage of the ulcer. 8. Enter the odor of the ulcer. 9. Enter the current treatment plan at the initiation of the pressure ulcer. 10. Enter the date of the last Dr. (doctor) progress note regarding Pressure ulcer. 11. Each week the ulcer is to be assessed and the following information collected on this form: a. Date. b. Stage. c. Length x width. d. Depth. e. Drainage. F. Odor. g. Progress/remarks - i.e. change in dressing type, schedule etc."

"Records need to reflect the accountability during the time frame of entry, which is best accomplished when nurses chart only their own observations and actions." Potter and Perry's Fundamentals of Nursing 6th edition, page 482.

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

The administrator was made aware of the above concern on 3/8/17 at 5:15 p.m.

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No further information was provided prior to exit.

1. This information was obtained from the following website:
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/
3. a. The facility staff failed to document physician ordered blood pressures and pulses on the January and February medication administration records (MARs) for Resident #6.

Resident #6 was admitted to the facility on 10/5/06 and readmitted on 5/1/12 with diagnoses that included but were not limited to: high blood pressure, Parkinson's disease (1), dementia, irregular heart beat and arthritis. The most recent minimum data set, a quarterly assessment, with an assessment reference date of 2/2/17 coded the resident as having long and short term memory problems and as impaired cognitively to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of Resident #6's care plan documented, "Focus Impaired Cardiovascular status related to: Dx (diagnosis) of A-fib (atrial fibrillation 2), HTN (hypertension)...Interventions Observe for abnormal vital signs and report."

Review of the physician orders dated 3/1/17 documented, "BP (blood pressure) and pulse qwk (every week) in the afternoon every Sun (Sunday) related to ESSENTIAL HYPERTENSION (high blood pressure)."

Review of the January 2016 MAR documented,

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"BP (blood pressure) and pulse qwk (every week) in the afternoon every Sun (Sunday) related to ESSENTIAL HYPERTENSION (high blood pressure)." Review of the MAR for 1/15/17 did not evidence documentation of the blood pressure or pulse.

Review of the February MAR documented, "BP (blood pressure) and pulse qwk (every week) in the afternoon every Sun (Sunday) related to ESSENTIAL HYPERTENSION (high blood pressure)." Review of the MAR for 2/12/17 and 2/19/17 did not evidence documentation of Resident #6's blood pressure or pulse.

On 3/8/17 at 5:15 p.m. a policy on completing the clinical record was requested from ASM (administrative staff member) #1, the administrator.

A telephone interview was conducted on 3/9/17 at 10:53 a.m. with LPN (licensed practical nurse) #13, the nurse who did not document the blood pressure or pulse on 2/6/17. When asked what did a blank space on the MAR mean, LPN #13 stated, "It can be one of two things. Either it wasn't done or it wasn't documented," When asked if she had cared for Resident #6, LPN #13 stated she had. When the MAR was reviewed with LPN #13 she stated, "I always keep a book with the vital signs. I remember taking the blood pressure (on Resident #6) but I didn't chart it."

An interview was conducted on 3/9/17 at 11:20 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked why it was important for staff to chart on the resident's record, ASM #2 stated, "To follow the doctor's orders and to be able to look at it (the

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documentation)."

ASM #2 was made aware of the findings at that time. An additional request was made for a policy on clinical documentation.

On 3/9/17 at 11:32 p.m. ASM #1, the administrator stated, "We have exhausted all of our efforts to locate those policies." No policies were received.

No further information was provided prior to exit.

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

(1) Parkinson's disease -- Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families. Exposure to chemicals in the environment might play a role. This

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information was obtained from: https://medlineplus.gov/parkinsonsdisease.html

(2) Atrial fibrillation - An arrhythmia is a problem with the speed or rhythm of the heartbeat. Atrial fibrillation (AF) is the most common type of arrhythmia. The cause is a disorder in the heart's electrical system. This information was obtained from: https://medlineplus.gov/atrialfibrillation.html

b. The facility staff documented that Resident #6 had her Prevalon boots on when they were not.

An observation was made on 3/7/17 at 3:35 p.m. of Resident #6. The resident was in bed. The resident was not wearing any heel boots.

An observation was made on 3/8/17 at 8:55 a.m. of Resident #6. The resident was sitting in the dining room. She was wearing a white pair of crocs shoes.

An observation was made on 3/8/17 at 4:25 p.m. of Resident #6. The resident was in the auditorium. She was wearing the white shoes.

An observation was made on 3/9/17 at 9:30 a.m. of Resident #6. The resident was sitting up in a chair next to her bed. She was wearing the white shoes.

Review of the physician's orders dated 9/27/16 documented, "Prevalon boots to bilateral feet at all times, remove for hygiene and skin checks every shift."

Review of the care plan initiated on 12/15/11 and revised on 2/15/17 documented, "Focus At risk for Pressure ulcer due to: requires Assist with bed

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mobility and toileting....edema to lower ext's (extremities). Interventions. Prevalon Boots on at all times except for hygiene and bathing."

Review of the March 2017 treatment administration record documented, "Prevalon boots to bilateral feet at all times, remove for hygiene and skin checks every shift." For each shift it was documented that the heel protectors were on.

An interview was conducted on 3/8/17 at 4:25 p.m. with ASM (administrative staff member) #2, the director of nursing and RN (registered nurse) #1, the assistant director of nursing. ASM #2 made an observation of the above observation of Resident #6 without heel boots in place. When asked if the resident was to have protective boots on, ASM #2 stated, "(RN #1) is she to have boots?" RN #1 stated, "Yes. She had a heel sore but it's better now."

An interview was conducted on 3/9/17 at 9:45 a.m. with LPN (licensed practical nurse) #12, the nurse caring for Resident #6. When asked if the resident was to have heel protectors on, LPN #12 stated, "Let me check. Yes she is." When asked when the protectors should be on, LPN #12 stated, "At all times." When asked how staff knew if the heel protectors were on, LPN #12 stated, "You're going around when you're doing your med (medication) pass and checking to make sure they have everything they need." LPN #12 was informed about the observations of Resident #6 not wearing the heel protectors and informed that staff documented the heel protectors (boots) as being on Resident #6 on the treatment administration record. LPN #12 stated it was documented in error.

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F 514	Continued From page 97 An interview as conducted on 3/9/17 at 11:20 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked why it was important for staff to accurately chart on the resident's record, ASM #2 stated, "To follow the doctor's orders and to be able to look at it (the documentation)." ASM #2 was made aware of the findings at that time. No further information was provided prior to exit.	F 514		