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
	495384	A. BUILDING _____ B. WING _____	C 03/02/2017

NAME OF PROVIOER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCIS MARION MANOR HEALTH & REHABILITATION	100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	[X5] COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/28/17 through 03/02/17. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 110 certified bed facility was 103 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents 1 through 18 and 24) and 5 closed record reviews (Residents 19 through 23).	F 000		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records,	F 164	F164 Privacy of health information of those served is important to the team at FMM 1. Immediate counseling was conducted with nurse to use the privacy pages when stepping away from her medicine cart to cover any resident information. 2. All residents have the potential to be affected by the same practice. Continued	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jan Martin LNHA | TITLE: Administrator | (X6) DATE: 3/28/17

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

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F 164	Continued From page 1	F 164	Continued	

regardless of the form or storage method of the records, except when release is-

(i) To the individual, or their resident representative where permitted by applicable law;

(ii) Required by Law;

(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;

(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview the facility staff failed to protect private health care information for 1 of 24 Residents, Resident #10.

The findings included:

For Resident #10 the facility staff failed to close/cover the medication administration record containing personal health care information while staff was not in attendance.

Resident #10 was admitted to the facility on 06/15/14 and readmitted on 06/06/16. Diagnoses included but not limited to anemia, atrial fibrillation, coronary artery disease, hypertension, peripheral vascular disease, end stage renal disease, hyponatremia, anxiety, hypothyroidism,

3. Nurses were re-educated to use privacy covers during medication passes through 1:1 sessions and will be reinforced during Skills Fair April 12, 2017.

4. The RN Nurse Manager (DON) or designee will audit medication passes to monitor privacy 4 x weekly x 12 weeks and monthly for six months. Data will be reported to the QAPI team for further interventions as determined needed.

5. Corrective action will be complete by 04/14/17.

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F 164	Continued From page 2 arthritis, depression and asthma. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/25/17 coded the Resident as 15 out of 15 in section C, cognitive patterns. This is an annual MDS. On 03/01/17 at approximately 0830, the surveyor observed the medication cart setting outside of Resident #10's room. The nurse was not in attendance. The surveyor observed the medication administration book open on the cart, with private health information for Resident #10 visible. On 03/01/17 at approximately 0930, the surveyor spoke with the DON (director of nursing) and asked what the procedure was for protecting health information during a med pass. The DON stated that the nurses have cover sheets to place over the MARs (medication administration record) when away from the cart. The concern of not covering the MAR while not in attendance was discussed with the administrative staff during a meeting on 03/01/17 at approximately 1710. No further information was provided prior to exit.	F 164		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 241	F241 Maintaining dignity of residents during dressing changes is important to the team at FMM Continued	

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F 241	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review it was determined the facility staff failed maintain/enhance the dignity of 1 of 17 residents (Resident #3) during a dressing change. Findings: Facility staff failed to maintain and the dignity of Resident #3 during a dressing change procedure. The surveyor reviewed Resident #3's clinical record on 3/1/17 and 3/2/17. Resident #3 was admitted to the facility 10/5/16, with diagnoses thal included but not limited to anemia, high blood pressure, decubitus ulcer, hypothyroidism, and adult failure to thrive. Resident #3's currenl minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/17 assessed the resident with a cognitive summary score of 99. Section G coded the resident to require assistance with activities of daily living. Resident #3's current comprehensive care plan dated 1/13/17, identified the resident had a potential for skin impairment and pressure. On 3/1/17 at 2:15 p.m. a member of the survey team observed the wound care nurse change the dressing covering Resident #3's wounds. The nurse performed the dressing change per the current physician's order. The nurse then dated an allevyn dressing and placed it on the coccyx area wound, her next step was to place an allevyn dressing on the hip wound, however, she	F 241	Continued 1. Education provided to the team member regarding appropriate labeling of dressings and was documented in her education file. 2. All residents have the potential to be affected by the same practice. 3. Policy will be clarified by March 31, 2017 and education provided to other team members regarding appropriate labeling of dressings by April 12, 2017. 4. The RN Nurse Manager (DON) or designee will audit dressing changes for appropriate labeling techniques 3 x weekly x 12 weeks and monthly for six months. Data will be reported to the QAPI team. 5. Corrective action will be complete by 04/14/17.	

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F 241	Continued From page 4 wrote the date on it after placing the allevyn on the resident's hip. The surveyor informed the administrator and other administrative staff of the wound care issue during the end of the day meeting on 3/1/17 at 5:10 p.m. The surveyor requested the facility policy on handwashing/wound care. The surveyor informed the administrator and other administrative staff of the dignity issue during the end of the day meeting on 3/1/17 at 5:10 p.m. No further information was provided prior to the exit conference on 3/2/17.	F 241		
F 252 SS=D	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 252	F252 Maintaining a clean, sanitary, homelike environment is important to the team at FMM 1. On 3/1/17 the EVS team deep cleaned both resident rooms identified as needing attention. 2. All residents have the potential to be affected by the same practice. Continued	

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F 252	Continued From page 5	F 252	Continued	

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 review, the facility staff failed to ensure a clean, sanitary, homelike environment for 2 of 24 residents (Resident #7 and Resident #8).

The findings included:

1. The facility staff failed to ensure Resident #7's room was clean and sanitary and without odor.

Resident #7 was admitted to the facility 9/10/14 and readmitted 2/22/17 with diagnoses that included but not limited to ischemic colitis, gastritis, esophagitis, duodenal ulcer, hiatal hernia, hypertension, chronic obstructive pulmonary disease, chronic hypoxic respiratory failure, chronic kidney disease stage 4, hypothyroidism, severe dysmobility, vascular dementia with delusions, major depression, diabetes mellitus, atrial fibrillation, schizophrenia, coronary artery disease, sleep apnea, hyperlipidemia, diabetic foot ulcer, and history of stroke.

Resident #7's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/11/16 coded the resident with a cognitive summary score of 00 out of 15 in Section C Cognitive Patterns.

3. EVS team members were re-educated regarding proper cleaning techniques on 3/1/17. Cycle room cleaning will begin in April identifying 3-5 rooms weekly.

4. Audits will be conducted by the EVS Manager 10 x weekly x 12 weeks and 10 monthly for 6 months. Data will be reported to the QAPI team.

5. Corrective action will be complete by 04/14/17.

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F 252	Continued From page 6 The surveyor observed Resident #7 on 2/28/17 at 12:20 p.m. Resident #7 was positioned in bed with the head of the bed elevated and being fed by staff. The surveyor smelled an odor of urine in the room noticeable between Resident #7's bed and the roommate. Resident #7 was noted to have an indwelling Foley catheter. There was a fall mat on the floor between Resident #7 and the roommate. A dried yellow area approximately 3 inches in diameter was noted on the left side of Resident #7's bed in the area of the Foley drainage bag. The surveyor observed Resident #7 again on 3/1/17 at 8:05 a.m. Resident #7 was in bed. The surveyor smelled the urine odor again. The surveyor located the quality assurance registered nurse and asked if she smelled odors in Resident #7's room. QA RN stated she agreed there was a urine odor in the room. The surveyor informed the administrative staff of the above concern on 3/1/17 at 5:10 p.m. The surveyor reviewed the job title for EVS (environmental services) tech (technician) on 3/2/17 at 8:08 a.m. Part of the job title read "Daily Entrance Cleaning". Dust mop and wet mop floors was listed as part of the daily entrance cleaning. The job title also had a section that read "High Profile Cleaning". High Profile Cleaning included "9. Damp mop." The facility staff provided the surveyor with the "10 Step Cleaning Process" on 3/2/17. Position 9. Read to "damp mop." No further information was provided prior to the exit conference on 3/2/17.	F 252		

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F 252	Continued From page 7	F 252		

2. The facility staff failed to ensure a clean and sanitary homelike environment for Resident #8. Resident #8's room had a urine odor and multiple black scuff marks at the foot of the bed.

Resident #8 was admitted to the facility on 5/27/16 and readmitted on 10/02/16. Diagnoses included but not limited to anemia, anxiety, depression, insomnia, urinary tract infection and pressure ulcer.

The most recent MDS with an ARD (assessment reference date) of 2/10/17 coded the resident as 15 out of 15 in Section C, Cognitive Patterns.

The surveyor observed Resident #8 during the initial tour on 2/28/17 beginning at 10:35 a.m. The resident was in bed and noted to have a Foley catheter. An odor of urine was noticeable in the room.

A second surveyor observed Resident #8 on 3/1/17 at various times during the day and once again smelled a urine odor in the room.

The first surveyor observed Resident #8 again on 3/1/17 at 3:55 p.m. The urine odor was not as noticeable but at the foot of the resident's bed, the surveyor observed multiple black, scuffed areas centered around the left wheel and extending approximately 10-12 inches in all directions. The surveyor interviewed the environmental services technician (other #5) on 3/1/17 at 4:00 p.m. She was asked about her duties as an environmental services technician. She stated part of her job was to mop the floors. She stated she didn't mop every day. The environmental services technician was asked about the black scuff areas. She stated they

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F 252	Continued From page 8 were caused by the rubber coming off the wheel. She stated she had put a work order in for the wheel to be checked but had not cleaned the area. The surveyor informed the administrative staff of the odor in the room and the black scuffed areas on the floor of Resident #8's room on 3/1/17 at 5:10 p.m. The surveyor reviewed the job title for EVS tech on 3/2/17 at 8:08 a.m. Part of the job title read "Daily Entrance Cleaning". Dust mop and wet mop floors was listed as part of the daily entrance cleaning. The job title also had a section that read "High Profile Cleaning". High Profile Cleaning included "9. Damp mop." The facility staff provided the surveyor with the "10 Step Cleaning Process" on 3/2/17. Position 9. Read to "damp mop." No further information was provided prior to the exit conference on 3/2/17.	F 252		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (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.	F 272	F272 Completing Section V of the MDS accurately is important to the team at FMM 1. Records were reviewed and it was determined the plan of care was not effected by improper documentation on the CAA worksheet for Residents #2, #4, #14 or #7.	

Continued

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F 272	Continued From page 9 (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. 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 and clinical record review, the facility staff failed to accurately complete Section V of the MDS (Minimum Data Set) for 4 of 24 Residents in the survey sample	F 272	Continued 2. All residents have the potential to be affected by the same practice. 3. MDS team members were re-educated regarding proper completion of Section V of the MDS. A check sheet was developed for team members to use to assist in making sure requirements are addressed. 4. The RN Nurse Manager (DON) will audit the work sheet weekly for 12 weeks and the CAA worksheet 4 x monthly for 6 months. Data will be reported to the QAPI team. 5. Corrective action will be complete by 04/14/17.	

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F 272	Continued From page 10 (Resident #2, #4, #14 and #7).	F 272		

The findings included:

1.The facility staff failed to document the dates and/or locations for where the documentation could be found in Resident #2's clinical record for Section V of the Care Area assessment (CAA) Summary of the Minimum Data Set (MDS).

Resident #2 was admitted to the facility on 2/27/16 with the following diagnoses of, but not limited to anemia, high blood pressure, heart failure, diabetes, anxiety disorder, depression, chronic obstructive pulmonary disease, hyponatremia and hyperkalemia. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/27/17 with a BIMS (Brief Interview for Mental Status, an assessment tool used) with a score of 14 out of a possible score of 15. Resident #2 was also coded as supervision of 1 staff member for dressing and requiring limited assistance with personal hygiene.

The surveyor conducted a clinical record review of Resident #2's chart on 3/1/17. The surveyor noted that on the MDS with an ARD of 2/27/17 in Section V of the CAA Summary the dates and locations of the documentation to support the triggered area were not properly documented for ADL (Activities of Daily Living) Functional. Under the "Nature of the problem/condition" for ADL Functional the following was noted to be documented: "____ (name of resident) has ADL deficit r/t (related to) impaired mobility, lack of motivation, COPD (chronic obstructive pulmonary disease), CHF (congested heart failure), Anxiety,

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Depression, Anemia, Agitation. She refuses at times prior to last 7 days to allow staff to bath and perform hygiene. Diagnosis 2/27/17."

The MDS nurse #1 was notified of the above documented findings by the surveyor on 3/1/17 at approximately 2 pm. The MDS nurse #1 stated "I put where I get the information like if it was in an interview. I don't know why this was done this way. We have been using this computer system since August. I have put in a call to the computer support to speak to the MDS specialist there."

The administrative team was notified of the above documented findings in the end of the day conference on 3/1/17 at approximately 5:20 pm by the surveyor.

No further information was provided to the surveyor prior to the exit conference on 3/2/17.

2. The facility staff failed to document the dates and/or locations for where the documentation could be found in Resident #4's clinical record for Section V of the Care Area assessment (CAA) Summary of the Minimum Data Set (MDS).

Resident #4 was admitted to the facility on 3/14/16 with the following diagnoses of, but not limited to anemia, atrial fibrillation, coronary heart disease, high blood pressure, diabetes, stroke, dementia, and hepatic failure. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/19/16, the resident was coded as having a BIMS (Brief Interview for Mental Status, an assessment protocol) of 00 out of a possible score of 15. Resident #4 was also coded as being totally

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCIS MARION MANOR HEALTH & REHABILITATION	100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354

(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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dependent on 2 staff members for dressing, personal hygiene and bathing.

The surveyor conducted a clinical record review of Resident #4's chart on 3/1/17. The surveyor noted that on the MDS with an ARD of 12/19/16 in Section V of the CAA Summary the locations of the dates and/or documentation to support the following triggered area were not properly documented for: Urinary Incontinence and Indwelling Catheter and Pressure Ulcer.

The MDS nurse #1 was notified of the above documented findings by the surveyor on 3/1/17 at approximately 2 pm. The MDS nurse #1 stated "I put where I get the information like if it was in an interview. I don't know why this was done this way. We have been using this computer system since August. I have put in a call to the computer support to speak to the MDS specialist there."

The administrative team was notified of the above documented findings in the end of the day conference on 3/1/17 at approximately 5:20 pm by the surveyor.

No further information was provided to the surveyor prior to the exit conference on 3/2/17.

3. The facility staff failed to document the dates and/or locations for where the documentation could be found in Resident #14's clinical record for Section V of the Care Area assessment (CAA) Summary of the Minimum Data Set (MDS).

Resident #14 was readmitted to the facility on 11/15/16 with the following diagnoses of, but not limited to high blood pressure, hip fracture,

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dementia, constipation, dysphagia and generalized weakness. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/15/16, the resident was coded as having a BIMS (Brief Interview for Mental Status, an assessment protocol) of 00 out of a possible score of 15. Resident #14 was also coded as requiring extensive assistance of 1 staff member for eating and personal hygiene and being totally dependent on 2 staff members for bathing.

The surveyor conducted a clinical record review of Resident #14's chart on 3/2/17. The surveyor noted that on the MDS with an ARD of 12/19/16 in Section V of the CAA Summary the locations of the dates and/or documentation to support the following triggered area were not properly documented for: Communication, Psychosocial Well-Being, Mood State, Falls, Dehydration/Fluid Maintenance and Pressure Ulcer.

The MDS nurse #1 was notified of the above documented findings by the surveyor on 3/2/17 at approximately 12:00 pm. The MDS nurse #1 stated "I put where I get the information like if it was in an interview. I don't know why this was done this way. We have been using this computer system since August. I have put in a call to the computer support to speak to the MDS specialist there."

The administrative team was notified of the above documented findings in the end of the day conference on 3/2/17 at approximately 12:20 pm by the surveyor.

No further information was provided to the surveyor prior to the exit conference on 3/2/17.

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4. The facility staff failed to ensure a complete and comprehensive CAA (Care Area Assessment) for Resident #7.
The facility staff failed to document the date of the documentation describing Resident #7's clinical status and factors impacting care planning decisions on Section V-Care Area Assessment (CAA) Summary.

Resident #7 was admitted to the facility 9/10/14 and readmitted 2/22/17 with diagnoses that included but not limited to ischemic colitis, gastritis, esophagitis, duodenal ulcer, hiatal hernia, hypertension, chronic obstructive pulmonary disease, chronic hypoxic respiratory failure, chronic kidney disease stage 4, hypothyroidism, severe dysmobility, vascular dementia with delusions, major depression, diabetes mellitus, atrial fibrillation, schizophrenia, coronary artery disease, sleep apnea, hyperlipidemia, diabetic foot ulcer, and history of stroke.

Resident #7's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/11/16 coded the resident with a cognitive summary score of 00 out of 15 in Section C Cognitive Patterns. Section V CAA was reviewed. Resident #7 had care areas triggered and the decision to care plan the following: cognitive loss/dementia, visual function, communication, urinary incontinence and indwelling catheter, psychosocial well-being, activities, falls, nutritional status, dehydration/fluid maintenance, dental care, pressure ulcer, psychotropic drug use, and pain. The last column titled "Location and Date of CAA documentation" had "CAA WS (worksheet) dated 9/12/16 except for urinary and that section read "CAA WS dated

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9/12/2016 PN (progress note) by Physician on 08/11/2016."

The surveyor reviewed the CAA worksheets. The cognitive loss/dementia worksheet dated 9/12/16 read "difficult in understanding others r/t (related to) hearing impairment, hearing and vision highly impaired". There were no specific dates or location documented to support the triggered area.

The CAA worksheet dated 9/12/16 for vision had documentation that read "Receives antidepressant/antipsychotic meds (medications) for dx. (diagnosis) schizophrenia/dementia with delusions adm dx 09/10/14.

The communication worksheet dated 9/12/16 read "difficulty finishing her sentences /hearing impairment 09/09/16" and "uses electronic assistive devices at times 09/09/16." There was no specific areas where this information could be found.

The psychosocial CAA worksheet dated 9/12/16 did have a statement that read "little information from resident during MDS interview on 09/09/16."

Activities worksheet dated 9/12/16 read "Information obtained from activities notes 09/09/16."

Falls worksheet dated 9/12/16 read "9/11/15 d/c (discharge) summary states high risk for falls r/t (related to) blindness and hearing loss 09/09/16." There was no current information from 2016 as to where the dates and location of factors surrounding Resident #7's fall history could be located.

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Nutritional CAA worksheet dated 9/12/16 read "blindness per d/c summary 09/11/15, unaware of time, day, year and no recall from sock, bed, blue 09/09/16, difficulty understanding r/t (related to) hearing loss 09/09/16." There was no documentation as to the location of where the information was located.

Dehydration CAA worksheet dated 9/12/16 read "Diabetic left lateral foot ulcer 0.6 x 0.4 wound care committee notes 09/08/16."

Dental CAA worksheet dated 9/12/16 read "R/T (related to) hearing loss 09/09/16."

Pressure Ulcer CAA worksheet dated 9/12/16 did have a note that read "left lateral foot diabetic ulcer 0.6 x 0.4 improving per wound care committee notes 09/08/16, diabetic foot ulcer on low airloss/alternating pressure mattress."

Psychotropic Drug Use CAA worksheet dated 9/12/16 read "Adm (admission) dx (diagnosis): receives above medication for dx: schizophrenia/depression/anxiety/dementia with delusions." No specific admission dates or location where the information was found.
Pain CCA worksheet dated 9/12/16 read "Resident unable to answer questions regarding her pain on 09/09/16." There was no location or dates concerning the resident's pain location, interventions implemented, pain medications used, the use of non-verbal assessments, etc.

The surveyor interviewed minimum data set (MDS) registered nurse #2 on 2/28/17 at 5:00 p.m. MDS RN #2 reviewed the CAA worksheets and stated they were a work in progress. The

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F 272	Continued From page 17 MDS RN #2 stated the work sheets needed more specific places and dates. The surveyor informed the administrative staff of the above concern on 3/2/17 at 12:20 p.m. No further information was provided prior to the exit conference on 3/2/17.	F 272		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (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	F 278	F278 Completing an accurate MDS for all residents is a priority for the team at FMM 1. MDS modifications were completed for both resident #8 and #9 to reflect accurate coding. These were completed during the survey and provided to the survey team. 2. All residents have the potential to be affected by the same practice. 3. MDS team members were re-educated regarding proper coding of the MDS.	

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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 observation, staff interview and clinical record review the facility staff failed to ensure an accurate MDS (minimum data set) for 2 of 24 Residents, Resident # 8 and Resident #9.

The findings included:

1. For Resident #8, the facility staff incorrectly coded the Resident's upper extremity impairment level.

Resident #8 was admitted to the facility on 05/27/16 and readmitted on10/02/16. Diagnoses included but not limited to anemia, anxiety, depression, insomnia, urinary tract infection and pressure ulcer.

The most recent MDS with an ARD (assessment reference date) of 02/10/17 coded the Resident as 15 out of 15 in section C, cognitive patterns. Section G, function status, subsection G0400, functional limitation in range of motion coded the Resident as having no impairment to either upper or lower extremities. This is a quarterly MDS. The most recent comprehensive MDS with an ARD date of 06/03/16 coded the Resident as having both upper and lower extremity impairment in subsection G0400.

Surveyor observed Resident #8 on 03/01/17 at approximately 0850. Resident was noted to have

4. The RN Nurse Manager (DON) or designee will audit completed MDS 3 x weekly x 12 weeks and 5 x monthly x 6 months. Data will be reported to the QAPI team.

5. Corrective action will be complete by 04/14/17.

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a contracture to left upper extremity, with decreased mobility and range of motion.

The discrepancy in the coding of the Resident's range of motion was discussed with the administrative team during a meeting on 03/01/17 at approximately 1710.

The MDS coordinator provided the surveyor with a corrected MDS on 03/02/17 at approximately 0755.

No further information was provided prior to exit.

2. For Resident #9, the facility staff incorrectly recorded the Resident's height on the MDS.

Resident #9 was admitted to the facility on 09/01/16. Diagnoses included but not limited to hypertension, diabetes mellitus, dementia, and respiratory failure.

The most recent MDS with an ARD of 02/20/17 coded the Resident as 0 out of 15 in section C, cognitive patterns. Section K, subsection 0K0200 recorded the Resident's height as 62 inches. This is a quarterly MDS. The most recent comprehensive MDS recorded the Resident's height as 60 inches in subsection 0K0200.

The discrepancy in recording the Resident's height was discussed with the administrative team during a meeting on 03/01/7 at approximately 1710.

The MDS coordinator provided the surveyor with a corrected MDS on 03/02/17 at approximately 0755.

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F 278	Continued From page 20 No further information was provided prior to exit.	F 278		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's	F 280	F280 Updating care plans for all residents is a priority for the team at FMM 1. Resident #12's care plan was updated to resolve risk for elopement. Resident #13's care plan was updated to reflect MRSA and isolation. Copies of the updates were given to the survey team during the survey. 2. All residents have the potential to be affected by the same practice. 3. Re-educated team to update the care plan. Nurse who notes the order is responsible for updating the care plan. Will reinforce education during the Skills Fair April 12. Continued	

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F 280	Continued From page 21 strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 280	Continued 4. The RN Nurse Manager (DON) or designee will audit updated care plans 3 x weekly x 12 weeks and 5 x monthly x 6 months. Data will be reported to the QAPI team. 5. Corrective action will be complete by 04/14/17.	

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(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to review and revise the current comprehensive care plan for 2 of 24 residents (Resident #12 and Resident #13).

The findings included:

1. The facility staff failed to revise the current comprehensive care plan when Resident #12 was no longer an elopement risk.

The clinical record of Resident #12 was reviewed 2/28/17 and 3/1/17. Resident #12 was admitted to the facility 5/8/15 with diagnoses that included but not limited to left humeral fracture, urinary tract infection, diabetes mellitus, hypertension, vascular dementia, pacemaker, and hard of hearing.

Resident #12's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/23/16 assessed the resident with a cognitive summary score of 6 out of 15 and without any signs or symptoms of delirium, psychosis, or behaviors directed toward others. Resident #12 was also assessed to have no wandering behavior. Section G assessed Resident #12 to need extensive assistance of 2 people for bed mobility and toilet use and required total assistance of two people for transfers, locomotion off unit, dressing, personal hygiene and bathing. Resident #12 was assessed to have impairment in upper extremity

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on one side and impairment in both lower extremities.

The current comprehensive care plan dated 1/10/17 identified Resident #12 to be an elopement risk r/t (related to) dementia, impaired safety awareness. Interventions/tasks listed included "WANDER ALERT: Check function and placement Q (every) shift."

The February 2017 physician order had an order that read "Assess and check placement and function of wander guard every shift (wander guard is located on residents w/c (wheelchair)." Written beside the order was "D/C (discontinue) 1-17-17."

The surveyor reviewed the "Elopement/Unsafe Wandering Risk Assessment" completed 1/17/17. Question 6 read "Has the resident been observed wandering without purposeful reason?" The answer "No." 14. Comments read "Resident #12 no longer gets up in her wheelchair. If she gets up out of the bed she prefers the recliner."

The surveyor observed Resident #12 on 2/28/17 at 12:30 p.m. and on 3/1/17 at 8:10 a.m. During both observations, Resident #12 was in bed, eating her meals. The surveyor did not observe any type of wander guard on any medical equipment in the room.

The surveyor interviewed registered nurse #2 on 3/1/17 at 2:55 p.m. The surveyor asked R.N. #2 if the current care plan should have been revised after the elopement assessment was completed on 1/17/17. R.N. #2 stated the wander guard and elopement should have been resolved on the care plan.

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The surveyor informed the administrative staff of the above concern with the lack of the revision of Resident #12's care plan when the wander guard was discontinued and the resident was no longer an elopement risk during the end of the day meeting on 3/1/17 at 5:10 p.m.

No further information was provided prior to the exit conference on 3/2/17.

2. The facility staff failed to review and revise the comprehensive care plan for Resident #13.

Resident #13 was readmitted to the facility on 4/7/15 with the following diagnoses of, but not limited to heart failure, high blood pressure, neurogenic bladder, multiple sclerosis, seizure disorder, vascular stasis ulcer to right lower extremity, depression and chronic obstructive pulmonary disease. The resident was coded on the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/28/16 as having a BIMS (Brief Interview for Mental Status, an assessment protocol) score of 15 out of a possible score of 15. Resident #13 is also coded as requiring extensive assistance of 1 staff member for eating and personal hygiene and being totally dependent on 2 or more staff member for dressing and bathing.

The surveyor performed a clinical record review of Resident #13's medical record. During this review, the surveyor noted, in the nurses' notes, that a wound culture was obtained on the resident's vascular stasis ulcer to right lower extremity on 2/10/17. According to the resident's MAR (Medication Administration Record) for the month of February, 2017, the physician ordered "Doxycycline 100 mg (milligram) BID (twice a

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day) X (times) 7 days". This was started on 2/10/17 at 2100 (9 pm) according to the MAR. On 2/13/17 the wound culture result returned to the facility and showed that it was growing "Methicillin Resistant Staphylococcus Aureus (MRSA) ..."

According to the nurses' notes on 2/13/17, it was documented that Resident #13 was notified of the above lab results and the need to be moved to a different room so that she would not have a roommate until the infection had cleared. The resident and husband verbalized understanding of this room change per the nurses' notes.

The comprehensive care plan was reviewed by the surveyor on 2/28/17 and the following documentation was noted: "Impaired skin integrity r/t (related to) Venous stasis BLE". There was no documentation that included the resident had a wound culture that grew MRSA or that the resident was moved to another room for contact isolation.

The director of nursing was interviewed by the surveyor on 3/1/17 at approximately 10 am. The surveyor notified the director of nursing of the above documented findings. The surveyor asked who's responsibility was it to update the resident care plan when there was a change in the care or condition of the resident. The director of nursing stated "It is the responsibility of the nurse that takes the order. The nurses are able to update the care plan but we have only had this computer system in place since August and we are still working out the problems."

The administrative team was notified of the above documented findings by the surveyor on 3/1/17 at

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F 280	Continued From page 26 approximately 5:15 pm in the conference room. The surveyor asked for a copy of the current comprehensive care plan for Resident #13. On 3/2/17 at 8:20 am, the surveyor found a copy of Resident #13's care plan. The following entries were noted by the surveyor with a revision date of 3/1/17: "2/13/17 culture of venous stasis ulcer to (R) (right) le (lower extremity) positive for MRSA resident placed in isolation- contact I ..." No further information was provided to the surveyor prior to the exit conference on 3/2/17.	F 280		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:	F 309	F309 Following physician's orders appropriately is a priority for the team at FMM 1. Residents number 4, 13, 3, 8 and 11 physicians were called and all scenarios were explained. Clarification orders were received if needed. 2. All residents have the potential to be affected by the same practice. 3. Re-educated team regarding proper medication. Education will be reinforced during the Skills Fair on April 12. Assistant Nurse Managers have started verifying start and end dates on MARs. Continued	

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F 309	Continued From page 27 (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, the facility staff failed to follow physician's orders for 5 of 24 Residents in the survey sample (Resident #4, #13, #3, #8 and #11). The findings included: 1. The facility staff failed to follow physician orders for Resident #4. Resident #4 was admitted to the facility on 3/14/16 with the following diagnoses of, but not limited to anemia, atrial fibrillation, coronary heart disease, high blood pressure, diabetes, stroke, dementia, and hepatic failure. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/19/16, the resident was coded as having a BIMS (Brief Interview for Mental Status, an assessment protocol) of 00 out of a possible score of 15. Resident #4 was also coded as being totally dependent on 2 staff members for dressing, personal hygiene and bathing.	F 309	Continued 4. The RN Nurse Manager (DON) or designee will audit PRN meds and antibiotic meds to ensure meds are given as ordered 5 x weekly x 12 weeks and 5 x monthly x 6 months. Data will be reported to the QAPI team. 5. Corrective action will be complete by 04/14/17.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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During the clinical record review on 3/1/17, it was noted by the surveyor that on 12/6/16 the physician had ordered the following for Resident #4: Hydrocodone -Acetaminophen 5 mg (milligram)-325 mg tablet Take 1 tab (tablet)by mouth twice daily for pain. The MAR (Medication Administration Record) for the month of January, 2017 was also reviewed by the surveyor. On 1/16/17 at 2100 (9 pm) it was documented that the "medication was not available".

The surveyor reviewed the narcotic sign out sheet for the month of January, 2017 for the above mentioned medication. According to the "Controlled Substance Administration Record" the medication was not received from the pharmacy until 1/17/17 at 1430 (2:30 pm).

The surveyor asked for a listing of contents in the "STAT Box" that was located in the medication room. On this list, Hydrocodone-Acetaminophen 5 mg-325 mg was available for the staff to give to the resident until the medication had been delivered by the pharmacy.

On 3/1/17 at approximately 5:15 pm, the surveyor notified the administrative team of the above documented findings.

At 6:15 pm, the director of nursing asked to speak to the surveyor in the conference room. The director of nursing stated "The nurses have to call the physician and notify him of the unavailable medication. If the medication is in the STAT box, the physician has to call the pharmacist and ask the pharmacist to call the facility with a special code so the medication can be obtained. The pharmacy will call the facility with the code and 2 nurses have to witness the

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medication being taken out of the STAT box. In this case, this was not done."

No further information was provided to the surveyor prior to the exit conference on 3/2/17.

2. The facility staff failed to document non-pharmacological interventions prior to the administration of pain medications to Resident #13.

Resident #13 was readmitted to the facility on 4/7/15 with the following diagnoses of, but not limited to heart failure, high blood pressure, neurogenic bladder, multiple sclerosis, seizure disorder, vascular stasis ulcer to right lower extremity, depression and chronic obstructive pulmonary disease. The resident was coded on the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/28/16 as having a BIMS (Brief Interview for Mental Status, an assessment protocol) score of 15 out of a possible score of 15. Resident #13 is also coded as requiring extensive assistance of 1 staff member for eating and personal hygiene and being totally dependent on 2 or more staff member for dressing and bathing.

The surveyor performed a clinical record review of Resident #13's medical record on 2/28/17. The following pain medications were given to Resident #13: " ...Motrin 800 mg (milligram) 1 tablet by mouth on 2/25/17 at 2140 (9:40 pm) for complaints of leg pain, Dilaudid 2 mg on 2/2/17 at 2215 (10:15 pm), 2/3/17 at 0830 (8:30 am) for complaints of back pain, 2/12/17 at 0140 (1:40 am) for complaints of BLE (Bilateral Lower Extremity) pain and again on 2/13/17 at 1115 (11:15 am) for complaints of leg pain.

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The nurses' notes were reviewed by the surveyor for the above documented dates of times that the pain medications were given to the resident. There were no non-pharmacological interventions documented prior to the administration of these pain medications.

Resident #13's comprehensive care plan was also reviewed by the surveyor. Under the focus of Pain the following interventions were documented:

"Anticipate her need for pain relief and respond immediately to any complaint of pain.

"Monitor/record/report to Nurse and s/sx (signs or symptoms) of non-verbal pain ...

"Monitor/record/report to Nurse _____ (name of resident) complaints of pain or requests for pain treatment ...

"_____ (name of resident) is able to call for assistance when in pain, needs assist positioning, ask for pain medication, tell you how much pain is experienced, tell you what increase or alleviates pain ..."

The administrative team was notified of the above documented findings by the surveyor on 3/1/17 at approximately 5:15 pm.

No further information was provided to the surveyor prior to the exit conference on 3/2/17.

3. The facility staff failed to administer the physician ordered medication doxycycline 100mg by mouth BID x 7 days.

The surveyor reviewed Resident #3's clinical record on 3/1/17 and 3/2/17. Resident #3 was admitted to the facility 10/5/16, with diagnoses that included but not limited to anemia, high blood

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pressure, decubitus ulcer, hypothyroidism, and adult failure to thrive.

Resident #3's current minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/17 assessed the resident with a cognitive summary score of 99. Section G coded the resident to require assistance with activities of daily living.

Review of the clinical record revealed the physician had ordered the medication doxycycline 100mg by mouth BID x 7 days on 2/18/17.

The surveyor then reviewed the medication administration recorded (MAR) that revealed only 13 doses of the medication had been administered not the 14 ordered doses.

LPN # 6 was asked to look at the MAR and see if all the doses had been given. After looking she said "Looks like they didn't give them all."

At 3:20 on 3/1/17, the director of nurses was asked to look at the number of doxycycline documented on the MAR. She said "looks like 13 not 14."

The surveyor informed the administrator and other administrative staff of the medication issue during the end of the day meeting on 3/1/17 at 5:10 p.m.

No further information was provided prior to the exit conference on 3/2/17.
4. For Resident #8, the facility staff failed to follow physician's orders in regards to no bowel movements for 72 hours.

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Resident #8 was admitted to the facility on 05/27/16 and readmitted on10/02/16. Diagnoses included but not limited to anemia, anxiety, depression, insomnia, urinary tract infection and pressure ulcer.

The most recent MDS with an ARD (assessment reference date) of 02/10/17 coded the Resident as 15 out of 15 in section C, cognitive patterns.

Resident #8's clinical record was reviewed on 03/01/17. It contained bowel movement records for the months of December, January and February. For the month of December, the Resident went for a period of 5 days (12/01-12/06/16) with no recorded bowel movement and a period of 3 days (12/12-12/16/16) with no recorded bowel movement. For the month of January, the Resident went for a period of 4 days (01/01-01/14/17) with no recorded bowel movement and a period of 3 days (01/14-01/18/16) with no recorded bowel movement. For the month of February, the Resident went for a period of 3 days (02/03-02/05/17), a period of 4 days (02/06-02/10-17), a period of 8 days (02/11-02/19/17), a period of 4 days (02/21-02/25/17 and a period of 3 days (02/15-02/28-17) with no recorded bowel movements.

Resident #8's clinical record also contained signed POSs (physician's order summaries) for the months of December, January and February. Each POS contained an entry which read in part "Bisac-evac 10mg supp. (suppository) for Dulcolax-unwrap and insert 1 suppository rectally every 72 hours as needed for constipation".

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Resident #8's MARs (medication administration records) for the months of December, January and February were reviewed on 03/01/17.Each MAR contained an entry which read in part "Bisac-evac 10mg supp for Dulcolax-unwrap and insert 1 suppository rectally every 72 hours as needed for constipation". This order had not been signed as having been administered at any time during December or February, and only 1 time in January.

The concern of not following the physician's orders was discussed during a meeting with the administrative staff on 03/01/17 at approximately 1710.

No further information was provided prior to exit.

5. The facility staff failed to monitor and evaluate Resident #11's response to treatment for constipation.

The clinical record of Resident #11 was reviewed 2/28/17 and 3/1/17. Resident #11 was admitted initially 12/2/16 and readmitted 2/13/17 and 2/27/17 with diagnoses that included but not limited to pneumonia, sepsis, chronic obstructive pulmonary disease, anxiety, chronic pain, hypothyroidism, acute lumbar compression fracture, chronic lung disease, chronic steroid use, osteoporosis, gastroesophageal reflux disease, hyperlipidemia, seizures, right eye blindness and right facial paralysis.

Resident #11's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/9/16 assessed the resident with a cognitive summary score of 15 out of 15 in Section C Cognitive Summary. Section

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G assessed the resident to need limited assistance of 1 person for transfers. Resident #11 required extensive assistance of one person for toileting. Resident #11 was assessed to be occasionally incontinent of bowel in Section H Bladder and Bowel.

Resident #11's current comprehensive care plan initiated 12/16/16 identified constipation as a focus r/t (related to) decreased mobility, pain, side effects of medications. Intervention/tasks listed included to encourage warm prune juice or prunes each day, monitor medications for side effects of constipation. Keep physician informed of any problems. Monitor/document /report prn (whenever needed) s/sx (signs/symptoms) of complications related to constipation. Record bowel movement pattern each day.

The surveyor reviewed the B&B-Bowel and Bladder Elimination Report for February 2017. The B&B report revealed Resident #11 did not have a bowel movement for 5 days from 2/1/17 through 2/5/17, 2/13/17 through 2/17/17 (5 days) and 2/20/17 through 2/23/17 (4 days).

The 2/1/17 through 2/8/17 medication administration record was reviewed. Resident #11 had orders for Docusate sodium softgel 100 mg (milligrams) capsule for > Colace 1 cap by mouth twice a day as needed for constipation. Documentation on the February 2017 MAR indicated Resident #11 received Colace on the 7p-7a shift on 2/3/17, 2/4/17, and 2/5/17. The reverse side of the medication administration record did not reveal documentation of the Colace or if the medication administered was effective.

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The 2/1/17 through 2/8/17 medication administration record was reviewed. Resident #11 had orders for Lactulose 100 mg (milligrams)/15 ml (milliliters)solution for > Constulose then 20 ml (15 mg) by mouth as needed q (every) 8 hours. There was no documentation Resident #11 received Lactulose.

The 2/1/17 through 2/8/17 medication administration record also had a second order for constipation and read "Milk of Magnesia 400 mg/15 ml oral susp (suspension) for >Phillips Milk of Magnesia (MOM) 30 ml by mouth every day as needed constipation." There was no documentation that Resident #11 received MOM.

The surveyor reviewed the medication administration record from 2/13/17 through 2/23/17.

Resident #11 had orders for Lactulose 10G (Grams)/15 ml (milliliters) solution for > Constulose then 20 ml (20 G) by mouth twice daily as needed for constipation.

Resident #11 received Lactulose 20 ml on 2/18/17, 2/19/17 and 2/22/17. However, there was no indication if the medication administered was effective. There were no bowel movements documented from 2/13/17 through 2/17/17 (5 days) and 2/20/17 through 2/23/17 (4 days). Resident #11 did not receive medication for constipation from 2/13/17 through 2/17/17.

The surveyor reviewed the February 2017 progress notes. There was no documentation in the progress notes of Resident #11's bowel status.

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F 309	Continued From page 36 3/2/17 at 11:30 a.m., the DON stated the facility does print out a report each day for those residents that have not had a bowel movement. The DON stated the reports are given to the charge nurses. The surveyor informed the administrative staff of the concern with Resident #11's bowel movement status during the end of the survey meeting on 3/2/17 at 12:20 p.m. No further information was provided prior to the exit conference on 3/2/17.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow infection control	F 314	F314 Following infection control guidelines during wound care is a priority for the team at FMM 1. The RN providing wound care was counseled regarding proper dressing techniques. Resident #3 appears to have sustained no ill effects from the identified deficient practice. 2. All residents receiving wound care have the potential to be affected by the same practice. 3. Education provided. Peer to peer observation completed and education plan initiated. Re-education will be provided during the skills fair.	

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	495384	A. BUILDING _____ B. WING _____	C 03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCIS MARION MANOR HEALTH & REHABILITATION	100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354

(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 314	Continued From page 37	F 314	Continued	

guidelines during wound care for 1 of 26 residents (Resident #3).

The findings included:

The facility staff failed to wash hands during wound care for Resident #3.

The surveyor reviewed Resident #3's clinical record on 3/1/17 and 3/2/17. Resident #3 was admitted to the facility 10/5/16, with diagnoses that included but not limited to anemia, high blood pressure, decubitus ulcer, hypothyroidism, and adult failure to thrive.

Resident #3's current minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/17 assessed the resident with a cognitive summary score of 99. Section G coded the resident to require assistance with activities of daily living.

Resident #3's current comprehensive care plan dated 1/13/17 identified the resident had a potential for skin impairment and pressure.

The surveyor observed wound care on 3/1/17 at 2:15 p.m., with the wound care nurse. The wound care nurse cleaned and draped the over bed table; then gathered the supplies for wound care at the treatment cart and carried them into Resident #3's room. Using hand gel cleaned her hands and put on gloves then removed the old wound dressing from the hip. She removed her gloves and placed on new gloves, using wound cleanser and gauze, cleaned the wound on Resident #6's hip. She then sprayed wound cleanser on another gauze and cleaned the wound on Resident #6 coccyx area. She then

4. The RN Nurse Manager (DON) or designee will observe wound care to audit proper hand hygiene to be completed 3 x weekly x 12 weeks and monthly for six months. Data will be reported to the QAPI team.

5. Corrective action will be complete by 04/14/17.

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dated an allevyn dressing and placed it on the coccyx area wound; then place an allevyn dressing on the hip and wrote the date on it after placing the allevyn on the resident's hip. She removed her gloves and put on clean gloves to assist the CNA in positioning the resident. The wound care nurse washed her hands at the beginning of the wound care and after she finished.

The surveyor informed the administrator and other administrative staff of the wound care issue during the end of the day meeting on 3/1/17 at 5:10 p.m. The surveyor requested the facility policy on handwashing/wound care.

The facility policy titled "Pressure Injury: Treatment" was reviewed 3/2/17 at 9:20 a.m. The policy read in part: "14. Perform hand hygiene and don gloves; 17. Remove the dressing, if present, and dispose of it in the biohazard disposal device. 18. Remove gloves, perform hand hygiene, and don clean gloves. 22. Apply wound dressing. 23. Label the dressing per the organization's practice with the date and time of application and initial it. 26. Discard supplies, remove PPE (personal protective equipment), and perform hand hygiene."

No further information was provided prior to the exit conference on 3/2/17.

F 314

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

(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:

F 328

F328
Ensuring respiratory care equipment is maintained in a clean and sanitary manner for all residents is a priority for the team at FMM

Continued

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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F 328	Continued From page 39 (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, assisl 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 that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the	F 328	Continued 1. Concentrators for residents #5 and #7 were cleaned and filters changed immediately. 2. All residents who utilize concentrators have the potential to be affected by the same practice. So, all concentrators were cleaned and filters changed. 3. Process of changing filters was changed to every two weeks. 4. The RN Nurse Manager (DON) or designee will observe cleanliness of the concentrators by audit 4 x weekly x 12 weeks and 4 x monthly thereafter. Data will be reported to the QAPI team. 5. Corrective action will be complete by 04/14/17.	

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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, staff interview, facility document review and clinical record review, the facility staff failed to ensure respiratory care equipment was maintained in a clean and sanitary manner for 2 of 24 residents (Resident #5 and Resident #7).

The findings included:

1. The facility staff failed to ensure the filter on the oxygen concentrator was clean for Resident #5.

The surveyor reviewed the clinical record of Resident #5on 2/28/17 and 3/1/17. Resident #5 was admitted to the facility 8/13/15 with diagnoses that included but not limited to chest pain, heart failure, hypoxemia, pulmonary hypertension, urinary tract infections, atrial fibrillation, hyponatremia, major depressive disorder, anxiety, cataracts, and right bundle branch block.

Resident #5's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/7/17 assessed the resident with a

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cognitive summary score of 12 out of 15 and without signs or symptoms of delirium, psychosis or behaviors. Resident #5 was assessed to require oxygen while a resident at the facility.

Resident #5's current comprehensive care plan initiated 10/15/16 and revised 1/9/17 identified CHF (congestive heart failure) as a focus area and treated with O2 (oxygen) via NC (nasal cannula), diuretics and fluid restriction. Interventions/tasks listed in part were administer medications as ordered, monitor for respiratory distress and report to MD (medical doctor) prn (whenever necessary), O2 as ordered, as tolerated by resident.

The February 2017 physician order sheet was reviewed. The current order for Resident #5 for oxygen was 2 liters per nasal cannula as tolerated by resident.

The surveyor observed Resident #5 on 3/1/17 at 8:20 a.m. Resident #5 was observed in bed with the head of the bed elevated. There was an oxygen concentrator positioned to the right side of the bed. The surveyor was unable to view the amount of oxygen Resident #5 was receiving via the nasal cannula and requested the assistance of QA RN. QA RN stated the concentrator was on 6 not 2 as ordered. The surveyor and the QA RN also checked the oxygen filter. The filter was covered with a grayish white material. QA RN stated the filter was dirty. The surveyor asked who was responsible for the care of the oxygen concentrators and was informed that the restorative certified nursing assistant #4 was the person.

The surveyor interviewed the restorative C.N.A.

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#4 on 3/1/17 at 8:40 a.m. Restorative C.N.A. #4 stated he and a representative from the oxygen company rounded monthly and checked the filters and performed maintenance on the concentrators. Restorative C.N.A. #4 provided the surveyor with the last inspection and the form was dated 2/8/17. The restorative C.N.A. #4 stated filters were washed at least monthly and if a filter needed to be cleaned they were washed in the dishwasher. The restorative C.N.A. #4 stated there were extra oxygen filters kept at the facility.

The surveyor informed the administrative staff of the above concern with the care of oxygen filters in the end of the day meeting on 3/1/17 at 5:10 p.m. and requested the facility policy on maintenance of oxygen equipment.

The facility policy titled "Supplemental Oxygen Therapy-Francis Marion Manor" was reviewed 3/2/17. The policy read in part "E. Concentrators: 1. Safety issues are to be adhered by placing the system in a clutter-free environment that is well ventilated, away from walls, drapes, curtains, bedding, combustible materials, and at least eight (8) feet away from heat sources. a. NOTE: Do not place oxygen delivery system in a closet.
2. Wipe exterior with approved cleaning solution as needed. 3. Follow manufacturer's instructions for maintenance and other safety recommendations."

No further information was provided prior to the exit conference on 3/2/17.

2. The facility staff failed to ensure the filter on the oxygen concentrator was clean for Resident #7.

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Resident #7 was admitted to the facility 9/10/14 and readmitted 2/22/17 with diagnoses that included but not limited to ischemic colitis, gastritis, esophagitis, duodenal ulcer, hiatal hernia, hypertension, chronic obstructive pulmonary disease, chronic hypoxic respiratory failure, chronic kidney disease stage 4, hypothyroidism, severe dysmobility, vascular dementia with delusions, major depression, diabetes mellitus, atrial fibrillation, schizophrenia, coronary artery disease, sleep apnea, hyperlipidemia, diabetic foot ulcer, and history of stroke.

Resident #7's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/11/16 coded the resident with a cognitive summary score of 00 out of 15 in Section C Cognitive Patterns. Section O Special Treatments, Procedures, and Programs coded that Resident #7 received oxygen while a resident. The most recent quarterly MDS with an ARD of 12/8/16 also coded the resident with the use of oxygen while a resident.

Resident #7's current comprehensive care plan contained a focus area for oxygen therapy initiated 9/12/16 and revised 12/12/16. Interventions/tasks were in part : Monitor for signs/symptoms of respiratory distress and report to MD (medical doctor) prn (whenever necessary); respirations, pulse oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage, skin color. Promote lung expansion and improve air exchange by positioning with proper body alignment. Elevate

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head of bed to resident's tolerance.

Resident #7's March 2017 physician order sheet read "O2 (oxygen) @ (at) 2 L/M (liters per minute) via nasal cannula as tolerated."

The surveyor observed Resident #7 on 2/28/17 at 12:20 p.m. as the certified nursing assistant was feeding her. Resident #7 was observed with an oxygen concentrator to the left side of her bed and the oxygen concentrator was set at 2 liters/per minute. Resident #7 was observed to have the nasal cannula in her nostrils.

The surveyor observed Resident #7 again on 3/1/17 at 8:00 a.m. The oxygen concentrator was positioned at 2 liters/per minute and Resident #7 had the nasal cannula positioned in her nostrils.

The surveyor located the quality assurance registered nurse to check the oxygen filter located on the back of the oxygen concentrator. At 8:05 a.m., QA RN removed the filter from the oxygen concentrator. The filter was covered with a whitish to grayish substance. QA RN stated "We got a filter problem." The surveyor asked who was responsible for cleaning the filters and QA RN stated "Restorative certified nursing assistant #4 (RCNA #4)."

The surveyor interviewed the restorative C.N.A. #4 on 3/1/17 at 8:40 a.m. Restorative C.N.A. #4 stated he and a representative from the oxygen company rounded monthly and checked the filters and performed maintenance on the concentrators. Restorative C.N.A. #4 provided the surveyor with the last inspection and the form was dated 2/8/17. The restorative C.N.A. #4 stated filters were washed at least monthly and if

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a filter needed to be cleaned they were washed in the dishwasher. The restorative C.N.A. #4 stated there were extra oxygen filters kept at the facility.

The surveyor informed the administrative staff of the above concern with the care of oxygen filters in the end of the day meeting on 3/1/17 at 5:10 p.m. and requested the facility policy on maintenance of oxygen equipment.

The facility policy titled "Supplemental Oxygen Therapy-Francis Marion Manor" was reviewed 3/2/17. The policy read in part "E. Concentrators: 1. Safety issues are to be adhered by placing the system in a clutter-free environment that is well ventilated, away from walls, drapes, curtains, bedding, combustible materials, and at least eight (8) feet away from heat sources. a. NOTE: Do not place oxygen delivery system in a closet.
2. Wipe exterior with approved cleaning solution as needed. 3. Follow manufacturer's instructions for maintenance and other safety recommendations."

No further information was provided prior to the exit conference on 3/2/17.

F 328

F 332 SS=D 483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

(f) Medication Errors. The facility must ensure that its-

(1) Medication error rates are not 5 percent or greater;
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility

F 332

F332
Ensuring med error rates are 5% or below is a priority for the team at FMM

1. Education was provide to nurse caring for residents #14 and #24 regarding med pass and inappropriate crushing of meds.

Continued

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document review and clinical record review, the facility staff failed to ensure the medication error rate was less than 5 percent which affected 2 of 24 Residents in the survey sample (Residents #14 and #24).

The findings included:

1. The facility staff failed to properly administer a medication, Imdur, to Resident #14 during the medication pass and pour observation.

Resident #14 was readmitted to the facility on 11/15/16 with the following diagnoses of, but not limited to high blood pressure, dementia, constipation, atrial fibrillation, and generalized edema. The resident was coded on the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/20/17 as requiring extensive assistance of 1 staff member for eating and personal hygiene. Resident #14 was also coded as being totally dependent on 1 staff member for bathing.

During the medication pass and pour observation made by the surveyor on 3/1/17 at 8:20 am, Licensed Practical Nurse (LPN #1) gave the resident Imdur 30 mg (milligram) ER (extended release) 1 tablet. LPN #1 crushed this medication prior to the administration of the medication to the resident and the medication was placed in apple sauce. LPN #1 proceeded in the resident's room and administrated the above documented findings.

The surveyor reviewed the resident's MAR (Medication Administration Record) for the month of March, 2017, under the medication Imdur, the following was noted: "Not to be chewed or

2. All residents have the potential to be affected by the same practice.

3. Education provided and will be reinforced during the skills fair. Requested the pharmacy to bold the alert when the med cannot be crushed.

4. The RN Nurse Manager (DON) or designee will observe med passes 4 x weekly x 12 weeks and 4 x monthly x 6 months. Data will be reported to the QAPI team.

5. Corrective action will be complete by 04/14/17.

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crushed".

On 3/1/17 at 10 am, the surveyor requested a copy of the do not crush medication policy from registered nurse #1. The surveyor was provided a copy of the policy titled "Oral Dosage Forms That Should Not Be Crushed". In this policy under the section "Oral Dosage Forms That Should Not Be Crushed" listed Imdur tablets as one of the medications that are not to be crushed.

The director of nursing was notified of the above documented findings concerning the crushing of the medication, Imdur, prior to the administration to the resident. The director of nursing stated "That's one that you cannot crush."

On 3/1/17 at approximately 5:15 pm, the administrative team was notified of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 3/2/17.

2. The facility staff failed to properly administer a medication, Potassium Chloride, to Resident #24 during the medication pass and pour observation.

Resident #24 was admitted to the facility on 10/5/15 with the following diagnoses of, but not limited to high blood pressure, thyroid disorder, osteoporosis, dementia, and depression. The resident was coded on the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/21/16 as having a BIMS (Brief Interview for Mental Status, an assessment protocol) score of 2 out of a possible score of 15. Resident #24 was also coded as requiring

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F 332	Continued From page 48 extensive assistance from 1 staff member for dressing and personal hygiene. During the medication pass and pour observation made by the surveyor on 3/1/17 at 8:30 am, Licensed Practical Nurse (LPN #1) gave the resident Potassium Chloride ER (extended release) 20 meq 1 tablet. LPN #1 crushed this medication prior to the administration of the medication to the resident and the medication was placed in apple sauce. LPN #1 proceeded in the resident's room and administrated the above documented findings. The surveyor reviewed the resident's MAR (Medication Administration Record) for the month of March, 2017, under the medication Potassium Chloride, the following was noted: "Not to be chewed or crushed. May be mix in water. Do not chew." The director of nursing was notified of the above documented findings concerning the crushing of the medication Potassium Chloride prior to the administration to the resident. The director of nursing stated "That's one that you cannot crush. You can dissolve it in water then administer it to the resident" On 3/1/17 at approximately 5:15 pm, the administrative team was notified of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 3/2/17.	F 332		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		

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F 333	Continued From page 49 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 2 of 24 residents (Resident #7 and Resident #12) were free of a significant medication error. The findings included: 1. The facility staff failed to ensure Resident #7 was administered the correct physician ordered insulin. Resident #7 was admitted to the facility 9/10/14 and readmitted 2/22/17 with diagnoses that included but not limited to ischemic colitis, gastritis, esophagitis, duodenal ulcer, hiatal hernia, hypertension, chronic obstructive pulmonary disease, chronic hypoxic respiratory failure, chronic kidney disease stage 4, hypothyroidism, severe dysmobility, vascular dementia with delusions, major depression, diabetes mellitus, atrial fibrillation, schizophrenia, coronary artery disease, sleep apnea, hyperlipidemia, diabetic foot ulcer, and history of stroke. Resident #7's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/11/16 coded the resident with a cognitive summary score of 00 out of 15 in Section C Cognitive Patterns.	F 333	F333 Ensuring residents are free of significant med errors is a priority for the team at FMM 1. Nurse re-educated regarding proper administration of insulin when using sliding scale. 2. All residents receiving sliding scale insulin have the potential to be affected by the same practice. 3. Re-education regarding med pass, including sliding scale, will be reinforced during the skills fair April 12, 2017 4. The RN Nurse Manager (DON) or designee will observe med passes 4 x weekly x 12 weeks and 4 x monthly x 6 months to ensure proper administration/dose of insulin. Data will be reported to the QAPI team. 5. Corrective action will be complete by 04/14/17.	

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NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
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Resident #7's current comprehensive care plan initiated 9/12/16 identified the resident had a diabetic foot ulcer related to diabetes and interventions/tasks read in part to monitor blood sugar levels.

A review of the February 2017 and March 2017 physician orders revealed orders that read "Novolog U100 per s/s (sliding scale) before meals & (and) bedtime". The Insulin Documentation Sheet read "Overweight BMI (body mass index) 25-29.9." This category was circled for Resident #7. The corrective insulin read "70-150=0 units; 151-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units, 351-400=10 units."

The surveyor reviewed the results of the blood sugars and identified the following concerns:

2/1/17 0615 blood sugar was 198 yet no insulin was administered. The column for correction insulin was blank. Based on the order, Resident #7 should have received 2 units. There was no evidence the resident received the insulin.

2/10/17 0626 blood sugar was documented as 157 yet no insulin was administered. The column for correctional insulin given was blank. Based on the physician order, Resident #7 should have received 2 units. There was no evidence Resident #7 received the insulin.

2/11/17 at 1118, Resident #7's blood sugar was 221. The amount of correctional insulin given was blank. Resident #7 should have been administered 4 units. There was no evidence the resident received the insulin.

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F 333	Continued From page 51 2/12/17 at 1647 (4:47 p.m.), Resident #7's blood sugar was documented as 197. There was no documentation that correction insulin was administered. Resident #7 should have received 2 units. The surveyor reviewed the blood sugar results with the director of nursing (DON) on 3/1/17 at 3:00 p.m. The DON acknowledged there was no evidence Resident #7 was administered the correct amount of insulin based on the documentation. The surveyor informed the administrative staff of the above concern during the end of the day meeting on 3/1/17 at 5:10 p.m. No further information was provided prior to the exit conference on 3/2/17. 2. The facility staff failed to ensure Resident #12 was administered the physician ordered correct amount of insulin. The clinical record of Resident #12 was reviewed 2/28/17 and 3/1/17. Resident #12 was admitted to the facility 5/8/15 with diagnoses that included but not limited to left humeral fracture, urinary tract infection, diabetes mellitus, hypertension, vascular dementia, pacemaker, and hard of hearing. Resident #12's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/23/16 assessed the resident with a cognitive summary score of 6 out of 15 and without any signs or symptoms of delirium, psychosis, or behaviors directed toward others. Section G assessed Resident #12 to	F 333		

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need extensive assistance of 2 people for bed mobility and toilet use and required total assistance of two people for transfers, locomotion off unit, dressing, personal hygiene and bathing.

The current comprehensive care plan for Resident #12 was initiated 12/6/16 for diabetes mellitus and revised 12/23/16. Intervention/tasks were "Diabetes medication as ordered by doctor, refer to MAR (medication administration record). Monitor/document for side effects and effectiveness."

The February 2017 physician orders read in part "Check blood sugar before meals and at bedtime. Humalog 100 units/ml (milliliter) inject before meals and at bedtime per sliding scale; 0-150=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, 401-450=12 units, All documentation should be on insulin documentation sheet."

The surveyor reviewed the February 2017 insulin documentation sheet.

The 2/3/17 0735 blood sugar was 205. The correctional insulin administered was 2 units. Resident #12 should have received 4 units.

The 2/9/17 2305 (11:05 p.m.) blood sugar was 271. The correctional insulin administered was 4 units. Resident #12 should have been administered 6 units.

The 2/18/17 2314 (11:14 p.m.) blood sugar was 264. The correctional insulin documented was 4 units. Resident #12 should have received 6 units.

The 2/24/17 0749 blood sugar was 179. The

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F 333	Continued From page 53 correctional insulin administered was 0. Resident #12 should have been administered 2 units. The surveyor reviewed the blood sugar results with the director of nursing (DON) on 3/1/17 at 3:00 p.m. The DON acknowledged there was no evidence Resident #12 was administered the correct amount of insulin based on the documentation. The surveyor informed the administrative staff of the above concern during the end of the day meeting on 3/1/17 at 5:10 p.m. No further information was provided prior to the exit conference on 3/2/17.	F 333		
F 387 SS=D	483.30(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure timely physician visits for 1 of 24 Residents in the survey sample. (Resident #4) The findings included: Resident #4 was admitted to the facility on	F 387	F387 Ensuring timely physician visits for all residents is a priority for the team at FMM 1. Resident #4 was evaluated by the physician during her first and third 30 day period. There appears to have been no ill effects from not being seen by the physician during her second 30 day period. 2. All residents have the potential to be affected by the same practice.	

Continued

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F 387	Continued From page 54 3/14/16 with the following diagnoses of, but not limited to anemia, atrial fibrillation, coronary heart disease, high blood pressure, diabetes, stroke, dementia, and hepatic failure. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/19/16, the resident was coded as having a BIMS (Brief Interview for Mental Status, an assessment protocol) of 00 out of a possible score of 15. Resident #4 was also coded as being totally dependent on 2 staff members for dressing, personal hygiene and bathing. During the clinical record review on 3/1/17, it was noted by the surveyor that there was one progress note that could not be found in the clinical record. There was a progress note dated for 3/14/16 and the next progress note in the clinical record was dated for 5/12/16. On 3/1/17 at approximately 5:15pm, the administrative team was notified of the above documented findings by the surveyor. On 3/2/17 at approximately 10 am, the director of nursing returned to the surveyor and stated, "We missed the progress note for April." No further information was provided to the surveyor prior to the exit conference on 3/1/17.	F 387	Continued 3. Re-educated team and physicians regarding the required visit schedule. Beginning in April, a Nurse Practitioner will be on site three days weekly to assist in ensuring residents are evaluated as required or needed. 4. The RN Nurse Manager (DON) or designee will audit monthly x 6 months. Data will be reported to the QAPI team. 5. Corrective action will be complete by 04/14/17.	
F 456 SS=D	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms	F 456	F456 Ensuring temperatures are checked daily on the hydrocollators in the rehab department is a priority for the team at FMM Continued	

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F 456	Continued From page 55 Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review, and staff interview, the facility staff failed to ensure temperatures were checked daily on the hydrocollators in the rehabilitation department. The findings included: The surveyor and the quality assurance registered nurse #1 toured the rehabilitation department on 3/2/17 at 10:30 a.m. The surveyor was informed that the rehab department had a hot pack hydrocollator and a cold pack hydrocollator. The surveyor asked if temperatures for the hydrocollators were obtained. The rehab manager licensed physical therapy assistant stated temperatures were usually checked weekly maybe twice a week. The rehab manager stated he looked at the temperatures of the hydrocollators every day but didn't always record them. The surveyor reviewed the temperature log for 2017. The January 2017 temperature log had recorded temperatures for 4 dates (1/4/17, 1/13/17, 1/21/17, and 1/27/17). These were temperatures recorded for the hot pack hydrocollator. There were no recorded temperatures for the cold pack hydrocollator. The February 2017 hot pack hydrocollator temperature log had nine temperature recordings (2/3/17, 2/18/17, 2/20/17-2/24/17, 2/27/17 and 2/28/17). There were no recorded temperatures for the cold pack hydrocollator in February 2017.	F 456	Continued 1. No residents were affected by the deficient practice. 2. All residents have the potential to be affected by the same practice. 3. Educated team members regarding the requirement to check and log temperatures daily to ensure they are within appropriate range and contact Bio-med if out of range. 4. The Administrator or designee will audit 4x monthly x 6 months. Data will be reported to the QAPI team. 5. Corrective action will be complete by 04/14/17.	

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F 456	Continued From page 56 The Infection Control Log for January 2017 had no documentation that the hydrocollators' temperatures were checked or cleaned. The February 2017 infection control log had checks that the hydrocollators' temperatures were checked weekly, cleaned monthly, exterior cleaned weekly, used covers washed weekly or if soiled. The date on the log was 2/6/17 that each week the hydrocollators' temperatures were checked. The log for February 2017 was completed before the month had ended. The surveyor requested the facility policy on maintaining the hydrocollator from the quality assurance registered nurse on 3/2/17 at 11:10 a.m. The QA RN stated the facility had switched to a different rehabilitation company; however, QA RN stated the temperatures of the hydrocollators should be checked every day. The QA RN informed the surveyor 3/2/17 at 12:55 p.m. that the facility policy talks of temperatures of frozen packs but nothing about hot packs. The surveyor requested the facility policy on the care of the hydrocollators again. The surveyor informed the administrative staff of the above concern in a meeting on 3/2/17 at 12:20 p.m. No further information or policies were provided prior to the exit conference on 3/2/17.	F 456		
F 502 SS=D	483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The	F 502		

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facility is responsible for the quality and timeliness of the services.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to obtain a physician ordered labs for 3 of 18 Residents in the survey sample (Resident #2, #12 and #3).

The findings included:

1. The facility staff failed to obtain a physician ordered lab for Resident #2.

Resident #2 was admitted to the facility on 2/27/16 with the following diagnoses of, but not limited to anemia, high blood pressure, heart failure, diabetes, anxiety disorder, depression, chronic obstructive pulmonary disease, hyponatremia and hyperkalemia. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/27/17 with a BIMS (Brief Interview for Mental Status, an assessment tool used) with a score of 14 out of a possible score of 15. Resident #2 was also coded as supervision of 1 staff member for dressing and requiring limited assistance with personal hygiene.

The surveyor conducted a clinical record review of Resident #2's chart on 2/29/17. In performing this review, the surveyor noted that on 11/15/16, the physician wrote an order which stated "may check urinalysis."

The surveyor could not locate the results of the urinalysis that was ordered by the physician on 11/15/16.

F502
Obtaining physician ordered labs is a priority for the team at FMM

1. Lab orders for residents #2, #12 and #14 were clarified with the physician and new orders obtained as needed.

2. All residents have the potential to be affected by the same practice.

3. A new lab management process was developed and tracking tool initiated. Education provided to team and will be reinforced during the skills fair.

4. The Nurse Manager or designee will audit 5x weekly x 12 weeks and 10 x monthly for 6 months. Data will be reported to the QAPI team.

5. Corrective action will be complete by 04/14/17.

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On 2/28/17 at approximately 5:15 pm, the administrative team was notified of the above documented findings.

The administrative team was again notified of the above documented findings by the surveyor on 3/1/17 at approximately 12 noon.

No further information was provided to the surveyor prior to the exit conference on 3/1/17.

2. The facility staff failed to obtain a physician ordered laboratory test for Resident #12.

The clinical record of Resident #12 was reviewed 2/28/17 and 3/1/17. Resident #12 was admitted to the facility 5/8/15 with diagnoses that included but not limited to left humeral fracture, urinary tract infection, diabetes mellitus, hypertension, vascular dementia, pacemaker, and hard of hearing.

Resident #12's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/23/16 assessed the resident with a cognitive summary score of 6 out of 15 and without any signs or symptoms of delirium, psychosis, or behaviors directed toward others. Section G assessed Resident #12 to need extensive assistance of 2 people for bed mobility and toilet use and required total assistance of two people for transfers, locomotion off unit, dressing, personal hygiene and bathing. Resident #12 was assessed to be incontinent of bowel frequently.

The physician order dated 6/7/16 read in part "1. Heme stool x 1 re: anemia."

The surveyor reviewed the laboratory section of

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the clinical record but was unable to locate the results.

On 2/28/17 at 3:30 p.m., the surveyor informed QA RN that the results of the heme stool ordered on 6/7/16 were not found in the clinical record.

The surveyor informed the administrative staff of the physician order for heme stool ordered on 6/7/16 and unable to locate the results of that laboratory test in the end of the day meeting on 3/1/17 at 5:10 p.m.

QA RN stated to the surveyor on 3/2/17 at 12:20 p.m. that the surveyor wouldn't be finding the results of the lab test. "It wasn't done."

No further information was provided prior to the exit conference on 3/2/17.

3. The facility staff failed to obtain physician ordered laboratory tests a CBC (complete blood count) and CMP (comprehensive metabolic panel) lab test for Resident #14.

Resident #3 was admitted to the facility 12/15/11 with diagnoses that included but not limited to high blood pressure, heart failure, anxiety, diabetes, and hypothyroidism.

A review of Resident #3's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 1/27/17, the facility staff assessed the resident to understand and to usually understand. She was assessed to have a cognitive summary score of 00.

On 2/28/17, a review of Resident #3's clinical record revealed that the physician had given an order on 10/29/13, for a CBC and CMP every 2 months.

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A review of the laboratory reports in Resident #3's clinical record revealed no results for the laboratory every 2 months except for December 2016.

On 3/1/16 at 3:35 pm, the corporate nurse was asked to assist with locating the missing lab test. She said she would check.

On 3/1/17, during a meeting with the administrator, corporate nurse and director of nurses were informed of the missing CBC and CMP laboratory tests.

On 3/2/17 at 12:00 pm the corporate nurse informed the surveyor "somehow the nurses got off."

Prior to exit on 3/2/17, the above information was again discussed with the administrator, the director of nurses and other administration staff.

F 514 SS=E 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

F 514

F514
Ensuring a complete and accurate clinical record for all residents is a priority for the team at FMM

1. Resident #2's physician was notified and orders clarified. Residents #14, 13, 11 and 1 experienced no ill effects as a result of the practice.

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(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

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

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 5 of 24 Residents in the survey sample (Resident #2, #14, #13, #11, and #1).

The findings included:

1. The facility staff failed to ensure a complete and accurate clinical record for Resident #2.

Resident #2 was admitted to the facility on 2/27/16 with the following diagnoses of, but not limited to anemia, high blood pressure, heart failure, diabetes, anxiety disorder, depression, chronic obstructive pulmonary disease,

F 514 Continued

2. All residents have the potential to be affected by the same practice.

3. Education will be provided regarding the lab tracking tool, education provided to physicians by letter and 1:1 during survey and education provided regarding med pass and appropriate documentation.

4. The Nurse Manager or designee will audit for accuracy of complete medical record 5x weekly x 12 weeks and 10 x monthly for 6 months. Data will be reported to the QAPI team.

5. Corrective action will be complete by 04/14/17.

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	495384	A. BUILDING _____ B. WING _____	C 03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCIS MARION MANOR HEALTH & REHABILITATION	100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354

(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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hyponatremia and hyperkalemia. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/27/17 with a BIMS (Brief Interview for Mental Status, an assessment tool used) with a score of 14 out of a possible score of 15. Resident #2 was also coded as supervision of 1 staff member for dressing and requiring limited assistance with personal hygiene.

The surveyor conducted a clinical record review of Resident #2's chart on 3/1/17.
During the review, the surveyor noted that the physician had ordered a Hgb A1C To be drawn every 3 months on Resident #2. The surveyor found results of the Hgb A1C for 12/8/16 in the paper clinical record. The months of June, 2016 and September, 2016 were not in the paper chart.

The administrative team was notified by the surveyor of the above documented findings on 3/1/17 at approximately 5:20 pm in the conference room.

On 3/2/17 at 10 am, the director of nursing brought copies of the missing labs for the months of June and September, 2016 to the surveyor. The surveyor asked the director of nursing where she had found these results. The director of nursing stated "Instead of going through the big box downstairs that is going to be scanned in the clinical record, I called the lab and they faxed these results to me."

No further information was provided to the surveyor prior to the exit conference on 3/2/17.

2. The facility staff failed to ensure a complete and accurate clinical record for

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Resident #14.

Resident #14 was readmitted to the facility on 11/15/16 with the following diagnoses of, but not limited to high blood pressure, dementia, constipation, atrial fibrillation, and generalized edema. The resident was coded on the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/20/17 as requiring extensive assistance of 1 staff member for eating and personal hygiene. Resident #14 was also coded as being totally dependent on 1 staff member for bathing.

The surveyor conducted a clinical record review of Resident #14's medical record on 3/2/17. During this review the surveyor noted that there were two physician progress notes in the paper clinical record that did not include the date the physician visits were made nor were the progress dated by the physician.

The administrative team was notified of the above documented findings on 3/2/17 at approximately 12:25 pm in the conference room by the surveyor.

No further information was provided to the surveyor prior to the exit conference on 3/2/17.

3. The facility staff failed to maintain a complete and accurate medical record for Resident #13.

Resident #13 was readmitted to the facility on 4/7/15 with the following diagnoses of, but not limited to heart failure, high blood pressure, neurogenic bladder, multiple sclerosis, seizure disorder, vascular stasis ulcer to right lower extremity, depression and chronic obstructive

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

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pulmonary disease. The resident was coded on the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/28/16 as having a BIMS (Brief Interview for Mental Status, an assessment protocol) score of 15 out of a possible score of 15. Resident #13 is also coded as requiring extensive assistance of 1 staff member for eating and personal hygiene and being totally dependent on 2 or more staff member for dressing and bathing.

The surveyor performed a clinical record review of Resident #13's medical record on 2/28/17. The surveyor found that there were three physician progress notes that were not signed by the physician nor was the progress note dated for the date of the physician visit.

The administrative team was notified on 3/1/17 at 5:20 pm of the above documented findings by the surveyor.

No further information was provided to the surveyor prior to the exit conference on 3/2/17.
4. The facility staff failed to ensure a complete and accurate February 2017 medication administration record (MAR) for Resident #11.

The clinical record of Resident #11 was reviewed 2/28/17 and 3/1/17. Resident #11 was admitted initially 12/2/16 and readmitted 2/13/17 and 2/27/17 with diagnoses that included but not limited to pneumonia, sepsis, chronic obstructive pulmonary disease, anxiety, chronic pain, hypothyroidism, acute lumbar compression fracture, chronic lung disease, chronic steroid use, osteoporosis, gastroesophageal reflux disease, hyperlipidemia, seizures, right eye blindness and right facial paralysis.

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Resident #11's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/9/16 assessed the resident with a cognitive summary score of 15 out of 15 in Section C Cognitive Summary.

Resident #11's February 27, 2017 bedtime medication administration record (MAR) contained "holes", times when there was no documentation that the ordered medications had been given.

On 2/27/17 at bedtime there were no initials for the administration of Remeron, Phenytoin, Atorvastin, Budesonide, Sinemet, Naprosyn, Oxycontin, Gabapentin, Guaifenesin, Duo-Neb (midnight dose), and Robaxin.

The surveyor informed the administrative staff of the failure to document when medications were administered on the February 2017 in the end of the survey meeting on 3/2/17 at 12:20 p.m.

No further information was provided prior to the exit conference on 3/2/17.

5. The facility staff failed to ensure polytrim eye drops were documented.

The clinical record of Resident #1 was reviewed on 1/18/17 through 1/19/17. Resident #6 was admitted to the facility on 12/14/11 with diagnoses that included but were not limited to: anxiety, high blood pressure, gastroesophageal reflux, dementia, and thyroid disorder.

Resident #1's most recent MDS (minimum data set) assessment, with an ARD (assessment reference date) of 12/7/16 was reviewed. Section C (cognitive patterns) of this assessment coded

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the resident to have short and long term memory problems with severely impaired decision making. In section B, the resident was coded to sometimes understand and to usually be understood.
Resident #1's clinical record was reviewed on 3/1/17. Her physician's orders revealed an order for Polytrim eye drops 2 drops to left eye 4 x daily x1 week. The surveyor also reviewed the residents medication administration record (MAR). The medication polytrim was started on 2/20/17 at 2100. On 2/21/17 at 2100 the nurse had circled this area and written on the back of the MAR that the resident had refused the eye drops. However, on 2/23/17 at 2100 no recording was found indicating the medication had been administered. On 2/27/17 at 1400 and at 2100 there was no documentation.
ON 3/1/17, LPN #3 was asked if she had administered the eye drops. After looking at the MAR she stated, "I don't know why I didn't initial there, I gave the medication."
The surveyor informed the administrator and other administrative staff of the medication documentation issue during the end of the day meeting on 3/1/17 at 5:10 p.m.

No further information was provided prior to the exit conference on 3/2/17.

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F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: Clinical Records 12VAC5-371-360 (B. E)- cross reference to F164 and F514 Nursing Services 12VAC5-371-220 (B. C)-cross reference to F241, F309, F314, F328, F322 and F333 Maintenance and Housekeeping 12VAC5-371-370 (A)-cross reference to F252 and F456 Resident Assessment and Care Planning 12VAC5-371-250 (A.4. C. F)-cross reference to F272, F278 and F280 Physician Services 12VAC5-371-240-cross reference to F387 Diagnostic Services 12VAC5-371-310 (A)-cross reference to F502.	F 001	Ensuring compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities is a priority for the team at FMM. Clinical Records: Cross reference F164 and F514 to 12VAC5-371-360 (B.E) Nursing Services: Cross reference F241, F309, F314, F328, F322 and F333 to 12VAC5-371-220 (B.C) Maintenance and Housekeeping: Cross reference F252 and F456 to 12VAC5-371-370 (A) Resident Assessment and Care Planning: Cross reference F272, F278 and F280 to 12VAC5-371-250 (A.4 C. F) Physician Services: Cross reference F387 to 12VAC5-371-240 Diagnostic Services: Cross reference F502 to 12VAC5-371-310(A)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeri Martin LNHA

TITLE: Administrator

(X6) DATE: 3/28/17

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