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 A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED R-C 01/11/2017
	495338		

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF ABINGDON	600 WALDEN ROAD ABINGDON, VA 24210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		01/27/2017
	An unannounced Medicare/Medicaid revisit to the standard survey conducted 11/08/16 through 11/10/16, was conducted 01/10/17 through 01/11/17. One complaint was investigated during this survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. The census in this 120 certified bed facility was 96 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents #1 through #12 and Residents #14 and #15) and 1 closed record review (Resident #13).			
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to post the results of the most recent life safety code survey and failed to post a	F 167	F 167 1. The most recent life safety code survey and the last three preceding year's survey results with their corresponding plans of correction were placed in the survey binder on 1/12/17 by the Administrator and placed inside the front entrance of the building. A sign was posted at the reception area indicating the last three preceding year's survey results were available for review on 1/13/17 by the Regional Director of Clinical Services.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 01/25/2017

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

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notice of the availability of the last three preceding year's survey results and their corresponding plan of corrections.

The findings included.

During the initial tour of the facility on 1/10/17 at 11:45 a.m., the surveyor observed a sign on the wall in the front lobby at the receptionist's desk informing staff, visitors, and residents of the facility that the current survey results were available. The sign included a downward arrow and a white notebook titled "Survey Results" was lying on the table.

The surveyor checked the contents of the binder. The last survey found in the survey result book was dated 12/9/15. The letter sent to the administrator was dated 2/18/16. The surveyor was unable to locate the most current life safety code survey report. There was no posting or notification indicating the last three preceding year's survey results were available for review. The most recent survey report from 11/8/16 through 11/10/16 was not found in the survey result book.

A second surveyor conducted a group meeting with five (5) residents of the facility on 1/10/17 at 2:30 p.m. During this meeting the residents verbalized to surveyor #2 that they were aware of where the current survey results were kept.

The administrative staff were notified of the above concern during an end of the day meeting on 1/11/17 at 11:25 a.m.

No further information regarding this issue was provided to the survey team prior to the exit

2. No resident was identified but all residents and guests have the potential to be affected by this alleged deficient practice.

3. The Administrator was in-serviced by the Regional Director of Clinical Services on the current regulatory requirements related to availability of survey results for public review on 1/12/17.

4. An audit will be conducted weekly for 4 weeks, then monthly for 2 months and/or 100% compliance by the Administrator to determine compliance. The results of the audits will be presented by the Administrator to the Quality Assurance/Performance Improvement Committee monthly. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Unit Managers, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.

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conference.

F 280 483 20(d)(3), 483.10(k)(2) RIGHT TO
SS=D PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, the facility staff failed to review and revise the comprehensive care plan for 1 of 15 residents (Resident #110).

The facility staff failed to review and revise the comprehensive care plan when Resident #110's oxygen was discontinued on 8/20/16.

The findings included:

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1. Resident #110 comprehensive care plan was revised by discontinuing the oxygen care plan on 1/11/17 by the Unit Manager.

2. A 100% audit of all resident care plans for oxygen was completed on 1/25/17 by the MDS Registered Nurse, and the MDS Licensed Practical Nurse. No other resident care plans were found to be affected.

3. All licensed nurses were in-serviced on the management of oxygen care plans by the Director of Nursing, and the Assistant Director of Nursing from 1/11/17 – 1/25/17.

Resident #110 was admitted to the facility 5/9/11 and readmitted 4/1/14 with diagnoses that included but not limited to chronic obstructive pulmonary disease (COPD), heart failure, atherosclerotic heart disease, dementia with behavioral disturbances, depressive disorder, peripheral vascular disease, and gastroesophageal reflux disease.

Resident #110's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/24/16 assessed the resident with short term memory problems, long term memory problems, and as having severely impaired cognitive skills for daily decision making. Resident #110 was not assessed to have used oxygen during the look back period.

The surveyor observed Resident #110 on 1/10/17 at 1:35 p.m. Resident #110 was in bed with eyes closed. The surveyor did not observe oxygen in use. The surveyor observed Resident #110 on 1/11/17 at 7:45 a.m. Resident #110 was in bed and a certified nursing assistant was feeding the resident. No oxygen was observed to be in use.

The current comprehensive care plan dated 4/19/16 had the problem/need that Resident #110 used oxygen d/t (due to) COPD problem onset: 4/19/16 with a revision date of 7/7/16. Approaches were to administer medications, O2 (oxygen), and treatments per MD (medical doctor) order see current MAR (medication administration record), vital signs per protocol, observe for and document complications of COPD such as increased respiration rate, decreased O2 sats (oxygen saturations), cyanosis, productive cough, and increase work at

4. An audit of all oxygen care plans will be conducted weekly for 4 weeks, then monthly for 2 months and/or 100% compliance by the MDS Nurses. The results of the audits will be presented by the Director of Nursing to the Quality Assurance/Performance Improvement Committee monthly. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Unit Managers, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.

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breathing, and observe for changes in status and notify MD.

A review of Resident #110's January 2017 physician orders did not evidence a current order for oxygen.

The surveyor interviewed the unit manager licensed practical nurse #5 on 1/11/17 at 11:05 a.m. The unit manager was asked what staff person updated care plans. She stated MDS.

The surveyor interviewed MDS/licensed practical nurse #2 on 1/11/17 at 10:35 a.m. The surveyor informed MDS/LPN #2 that the current comprehensive care plan still had oxygen use as a problem/need and no current physician order for oxygen. MDS/LPN #2 stated then the oxygen needed to come off the care plan. MDS/LPN #2 stated she would research the oxygen.

On 1/11/17 at 1:10 p.m., MDS/LPN #2 provided the surveyor with a telephone order dated 8/20/16 that read in part "D/C (discontinue) O2 (oxygen)." MDS/LPN #2 stated she would update the care plan.

The surveyor informed the administrative staff of the failure of the facility staff to review and revise Resident #110's current comprehensive care plan when oxygen was discontinued on 8/20/16 in a meeting on 1/11/17 at 11:25 a.m.

No further information was provided prior to the exit conference on 1/11/17.

{F 309} 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING {F 309}
SS=D

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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, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by.
Based on staff interview and clinical record review, the facility staff failed to ensure the highest practicable well-being for 2 of 15 Residents in the survey sample, Residents #107 and #111.

1. The facility staff administered the physician ordered medication linzess to Resident 107 twice a day when it was ordered one time a day.

2. The facility staff failed to obtain vital signs every 8 hours for 5 days per physician order for Resident #111. The facility staff failed to obtain physician ordered vital signs on three (3) occasions out of 15 opportunities from 12/12/16 through 12/16/16 (5 days of vital signs ordered by the physician).

The findings included.

1. The facility staff administered the physician ordered medication linzess to Resident 107 twice a day when it was ordered one time a day.

Linzess (linaclotide) is a prescription medication used in adults to treat irritable bowel syndrome

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1. Resident #107 was assessed by the Unit Manager on 1/11/17. No adverse outcomes were noted. LPN #4 was inserviced by the Director of Nursing on 1/11/17 on physician order accuracy. The physician order for Linzess was clarified and entered correctly into the electronic medication administration system to be given once daily by the Unit Manager on 1/11/17.

   Resident #111 was assessed by the Unit Manager on 1/11/17. No adverse outcomes were noted. The Provider and Responsible Party were notified on 1/11/17 by the Unit Manager.

2. An audit of all physician orders to ensure accuracy was completed from 1/25/17 – 1/27/17 by the Unit Managers, the Director of Nursing, and the Assistant Director of Nursing. Issues identied were addressed immediately by the Director of Nursing.

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with constipation and chronic idiopathic constipation. "Idiopathic" means the cause of the constipation is unknown. (1)

The record review revealed that Resident #107 had been admitted to the facility 01/25/13. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes, heart failure, generalized anxiety, hypothyroidism, and insomnia.

Section C (cognitive patterns) of the resident's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/13/16 included a BIMS (brief interview for mental status) summary score of 14 out of a possible 15 points, indicating the resident was cognitively intact. Section H (bowel and bladder) was coded (2/1) to indicate the Resident was frequently incontinent of urine and occasionally incontinent of bowel. Section I (active diagnoses) was coded to indicate the Resident had an active diagnosis of constipation.

The Residents CCP (comprehensive care plan) included the problem area requires staff assistance with ADL's (activities of daily living).

Resident #107's clinical record included a current physicians order for linzess 145 mcg give 1 capsule by mouth daily. The original order date was documented as 02/15/16 the order had been revised on 12/03/16. The diagnosis for this medication was documented as constipation.

A review of Resident #107's eMAR's (electronic medication administration records) for December 2016 and January 2017 indicated that the facility nursing staff had been administering linzess twice

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3. Licensed Nurses were in-serviced on physician order accuracy from 1/11/17 – 1/25/17 by the Director of Nursing and the Assistant Director of Nursing.

4. An audit of new physician orders will be conducted daily for 5 days, then weekly for 3 weeks, then montly for 2 months and/or 100% compliance. The results of the audits will be presented monthly by the Director of Nursing to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Unit Managers, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.

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a day since 12/04/16.

The Resident was out for dialysis on 12/15/16, 12/17/16, 12/22/16, 01/05/17, 01/07/17, and 01/11/17 at 10 a.m. and only received the linzess one time a day on these days.

A review of the Resident's BM's (bowel movements) for the last 30 days indicated that Resident #107 had a BM on 12/11/16, 12/14/16, 12/16/16, 12/18/16, 12/19/16, 12/21/16, 12/22/16, 12/23/16, 12/25/16, 12/27/16, 12/28/16, 12/29/16, 12/31/16, 01/03/17, 01/05/17, 01/06/17, 01/08/17, and 01/09/17. During the clinical record review the surveyor did not find any information to indicate the Resident had complained of any bowel issues.

Resident #107 was observed by the surveyor on 01/10/17 at 1:10 p.m. and again on 01/11/17 at 7:15 a.m., the resident went out of the facility on 01/11/17 for a day trip. During these observations the surveyor spoke with the resident regarding their care at the facility. No complaints were voiced to the surveyor regarding medications or problems with BM's during these conversations.

On 01/11/17 at approximately 10:00 a.m. the nurse consultant was made aware that Resident #107 had been administered the linzess twice a day when the physician order was for one time a day. The facility identified LPN (licensed practical nurse) #4 as the nurse who revised Resident #107's order on 12/03/16.

On 01/11/17 at approximately 1:25 p.m. LPN #4 was interviewed by the surveyor. LPN #4 verbalized to the surveyor that some of the times for the resident's medications had been changed

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due to a conflict with dialysis and she must have inputted the wrong time frame on the computer for this medication (linzess) during the revision.

During a meeting with the survey team on 01/11/17 at approximately 3 10 p.m. the administrative staff of the facility were made aware that Resident #107 had been administered their linzess twice a day when the physician order was for one time a day.

No further information regarding this issue was provided to the survey team prior to the exit conference.

(1) This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a613007.html

2. The facility staff failed to obtain vital signs every 8 hours for 5 days per physician order for Resident #111. The facility staff failed to obtain physician ordered vital signs on three (3) occasions out of 15 opportunities from 12/12/16 through 12/16/16 (5 days of vital signs ordered by the physician).

The clinical record of Resident #111 was reviewed 1/10/17 and 1/11/17. Resident #111 was admitted to the facility 7/4/16 and readmitted 10/22/16 with diagnoses that included but not limited to fusion of spine, cervicothoracic region, chronic obstructive pulmonary disease, lymphoid leukemia, and rheumatoid arthritis.

Resident #111's fourteen (14) day minimum data set (MDS) with an assessment reference date of 11/4/16 assessed the resident with a cognitive summary score of 15 out of 15, indicating the

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resident was cognitively intact, with no signs of delirium, psychosis, or behaviors.

The clinical record had a physician order dated 12/12/16 1300 (1:00 p.m.) that read "1 ? (decrease) Metoprolol (1) to 25 mg (milligram) po (by mouth) bid (twice a day). 2. v (check) vitals q8° (every 8 hours) x 5 days."

Current comprehensive care plan with problem onset dated 7/21/16 for use of oxygen with a diagnosis of chronic obstructive pulmonary disease had approaches that included to obtain vital signs per protocol.

The surveyor reviewed the vital signs documented on the electronic flow sheet, on the December 2016 medication administration record, and in the departmental notes and was unable to locate all physician ordered vital signs. The December 2016 medication administration record had documentation of 12 sets of vital signs (blood pressure, pulse, respiration, and temperature) taken from 12/12/16 at 10:00 p.m through 12/16/16 at 2:00 p.m. The departmental notes had documentation of vital signs taken on 12/13/16 at 4:02 p.m. (duplicate documentation also found on the flowsheet for 12/13/16 at 7:26 p.m.), 12/14/16 at 1:40 a.m. (duplicate documentation found on the flow sheet for 12/13/16 at 9:06 p.m.) and 12/15/16 at 2:18 a.m.

The December 2016 electronic flowsheet for vital signs from 12/12/16 through 12/16/16 had eleven (11) documented sets of vital signs.

The staff failed to obtain 5 days/fifteen sets of vital signs for Resident #111. The facility staff failed to obtain physician ordered vital signs on

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{F 309}	Continued From page 10 three (3) occasions out of 15 opportunities from 12/12/16 through 12/16/16. The surveyor informed the director of nursing of the concern that the facility staff had not monitored Resident #111's vital signs every 8 hours for 5 days as ordered by the physician after a change in the dose of the antihypertensive medication Metoprolol on 1/10/17 at 2:30 p.m. The director of nursing informed the surveyor on 1/11/17 at 8:00 a.m. that the nurse practitioner who ordered the vital signs to be obtained was informed of the results of Resident #111's vital signs and was in agreement that they no longer needed to be done; however, the nurse practitioner failed to write an order to discontinue them. The director of nursing stated the staff were unable to locate any more vital signs. The surveyor informed the administrative staff of the failure of the facility staff to obtain physician ordered vital signs in the meeting on 1/11/17 at 11:25 a.m. No further information was provided prior to the exit conference on 1/11/17. (1) Metoprolol is used alone or in combination with other medications to treat high blood pressure. It also is used to prevent angina (chest pain) and to improve survival after a heart attack. Metoprolol also is used in combination with other medications to treat heart failure. Metoprolol is in a class of medications called beta blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure.	{F 309}		

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{F 309}	Continued From page 11 High blood pressure is a common condition and when not treated, can cause damage to the brain, heart, blood vessels, kidneys and other parts of the body. Damage to these organs may cause heart disease, a heart attack, heart failure, stroke, kidney failure, loss of vision, and other problems. This information was obtained from the website: https //medlineplus.gov/druginfo/meds/a682864.html	{F 309}		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections, Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. 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 provide the necessary care, service, and treatment for special needs for 2 of 15 Residents in the survey	F 328	F328 1. Resident #105 was assessed by the Unit Manager on 1/11/17. No adverse outcomes noted. The PICC Line was discontinued on 1/09/17 by the Physician. LPN #1 was in-serviced on PICC Line Dressing Changes by the Director of Nursing on 12/30/16. Resident #111 was assessed by the Unit Manager on 1/11/17. No adverse outcomes noted. The physician order for continuous oxygen was discontinued on 1/10/17 by the physician.	

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	495338		R-C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF ABINGDON	600 WALDEN ROAD ABINGDON, VA 24210

(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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sample, Resident #105 and #111.

1. For Resident #105, the facility staff failed to change a PICC line dressing weekly as ordered by the physician.

2. For Resident #111, the facility staff failed to follow physician orders for the use of oxygen.

The findings included:

1. For Resident #105, the facility staff failed to change a PICC line dressing weekly as ordered by the physician.

A PICC line is a peripherally inserted central catheter. It is used for treatments such as intravenous fluids (IV), drugs, or blood transfusions (1)

The record review revealed that Resident #105 had originally been admitted to the facility 04/15/14. Diagnoses included, but were not limited to, diabetes, hypertension, trigeminal neuralgia, muscle weakness, and depressive disorder.

Section C (cognitive patterns) of the residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/25/16 included a BIMS (brief interview for mental status) summary score of 7 out of a possible 15 points, indicating the resident was moderately impaired for cognition.

The clinical record included a nursing entry dated 12/20/16 at 11:08 a.m. stating that Resident #105 was transported to a local hospital for "...PICC placement." This PICC line was to be used for IV

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2. No current residents have PICC Lines in place on 1/25/17.
An audit of all oxygen physician orders was completed on 1/20/17 by the MDS Nurses. No other residents were found to be affected.

3. Licensed Nurses were in-serviced from 1/11/17 – 1/25/17 on following physician orders by the Director of Nursing and the Assistant Director of Nursing.

4. An audit of all PICC Line Dressing Changes and Oxygen Physician Orders will be completed weekly for 4 weeks, then monthly for 2 months and/or 100% compliance by the Unit Managers or designee. The results of the audits will be presented by the Director of Nursing monthly to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Unit Managers, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services

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F 328	Continued From page 13 therapy to treat a urinary tract infection. The clinical record also included a physician telephone order dated 12/20/16 to change PICC line dressing weekly and as needed if moist or soiled A review of Resident #105's eTAR's (electronic treatment administration records) for 12/2016 and 01/2017 revealed that for the month of 12/2016 the dressing was scheduled to be changed on 12/27/16 at 7:00 a.m. However, LPN (licensed practical nurse) #1 had placed an "N" in the administration block for this date. Per the pre-printed code on the eTAR N meant "not administered." LPN #1 had made a nursing entry on the eTAR that read "...Change PICC line dressing weekly as...scheduled for 12/27/2016 7:00 A.M. was not administered..." The clinical record included a nursing note transcribed on 12/30/16 at 2:26 a.m. by LPN #8 that read "ADON (assistant director of nursing) came to this Nurse to fill out report on dressing not being changed on 12/27/16. Other Nurse changed dressing on 12/29/16. Dressing clean, dry and intact. No redden (sic) areas seen. Flushes well. MD (medical doctor) and ADON aware. Client aware..." The facility nursing staff documented they had changed the PICC line dressing again on 01/05/17 and the PICC line had been discontinued and removed on 01/09/17. The administrative staff were made aware of the issue involving the PICC line dressing not being changed during a meeting with the survey team on 01/11/17 at approximately 11:25 a.m.	F 328	Director, Therapy Services Director and the Medical Director.	01/27/2017

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F 328	Continued From page 14 Prior to the exit conference the facility staff provided the surveyor with a copy of a "MEDICATION ERROR REPORT" signed and dated by LPN #1 on 12/30/16. This medication error report revealed that LPN #1 failed to change the Residents PICC line dressing on 12/27/16. Outcome to Resident-No negative outcome. Corrective action-dressing changed immediately. Measures taken to prevent the recurrence of similar error(s)-PICC line dressing change inservice given. Copy of policy and dressing instructions given. Confusion noted by nurses on date PICC line placed. The facility staff also provided the surveyor with a copy of an inservice education sign in sheet. This inservice education sheet was titled "PICC Line Drsg (dressing). Change" and was also dated 12/30/16 and signed by LPN #1. On 01/11/17 at approximately 1:15 p.m. the surveyor interviewed Resident #105 regarding their PICC line care. Resident #105 stated that she never had any problems with the PICC line and that the facility staff took care of it. On 01/11/17 at approximately 2:50 p.m. the nurse consultant provided the surveyor with a copy of their policy titled "PERIPHERALLY INSERTED CENTRAL CATHETER (PICC) DRESSING CHANGE." This policy/procedure read in part "...Dressing changes using transparent dressings are performed...at least weekly..." On 01/11/17 at 2:54 p.m. the surveyor attempted to contact LPN #1 via the phone number provided by the facility. The call went to voicemail. No message was left. No further information regarding this issue was	F 328		01/27/2017

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F 328	Continued From page 15 provided to the survey team prior to the exit conference. (1) This information was obtained from the website: <https://www.cancer.gov/publications/dictionaries/cancer-terms?CdrID=689626> 2. The facility staff failed to follow physician orders for the use of oxygen for Resident #111. The clinical record of Resident #111 was reviewed 1/10/17 and 1/11/17. Resident #111 was admitted to the facility 7/4/16 and readmitted 10/22/16 with diagnoses that included but not limited to fusion of spine, cervicothoracic region, chronic obstructive pulmonary disease (COPD), lymphoid leukemia, and rheumatoid arthritis. Resident #111's fourteen (14) day minimum data set (MDS) with an assessment reference date of 11/4/16 assessed the resident with a cognitive summary score of 15 out of 15, indicating the resident was cognitively intact with no signs of delirium, psychosis, or behaviors. Resident #111's current comprehensive care plan with problem onset dated 7/21/16 for use of oxygen with a diagnosis of chronic obstructive pulmonary disease had approaches that included to administer medications, O2 (oxygen) and breathing treatments as ordered. See current MAR (medication administration record). Observe for complications r/t (related to) COPD such as increased respiratory rate, decreased O2 sats (oxygen saturations), cyanosis, SOB (shortness of breath), and report, and obtain vital signs per protocol.	F 328		01/27/2017

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The January 2017 physician order sheet was reviewed 1/10/17. Resident #111 had orders that read in part "O2 at 2 liters via nasal cannula continues (sic)."

The surveyor observed Resident #111 on 1/10/17 at 1:40 p.m. The resident was in bed with eyes closed. An oxygen concentrator was observed at the head of the bed on the left side. The concentrator was not turned on and the surveyor saw no tubing near or on Resident #111.

The surveyor observed Resident #111 on 1/10/17 at 4:05 p.m. The resident was in bed with eyes closed No oxygen in use. The surveyor approached the unit manager licensed practical nurse #5 on 1/10/17 at 4:05 p.m. The surveyor informed the unit manager of the current physician order and confirmed Resident #111 did not have the oxygen as ordered. "You're right. It's turned off."

The surveyor interviewed licensed practical nurse #4 on 1/11/17 at 7:40 a.m. L.P.N. #4 stated the resident had not used oxygen since returning from the hospital in October. The resident stated she didn't need the oxygen continuous and did not need oxygen at the present time.

The surveyor informed the administrative staff of the failure of the facility staff to follow physician orders for the use of oxygen in the meeting on 1/11/17 at 11:25 a.m.

No further information was provided prior to the exit conference on 1/11/17.

{F 431} 483.60(b), (d), (e) DRUG RECORDS, {F 431}

(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 431} SS=D	Continued From page 17 LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	{F 431}	F431 1. Resident #114 was assessed by the Unit Manager on 1/25/17. No adverse outcomes noted. The Novalog Insulin vial was discarded by the Unit Manager on 1/11/17. Resident #115 was assessed by the Unit Manager on 1/25/17. No adverse outcomes noted. The Pazeo eye drops were discarded by the Unit Manager on 1/11/17. 2. All insulin vials and eye drops were audited to ensure all were dated upon opening by the Unit Managers on 1/11/17. No other issues were identified. 3. Licensed Nurses were in-serviced on dating insulin vials and eye drops upon opening from 1/11/17 – 1/25/17 by the Director of Nursing and the Assistant Director of Nursing.	01/27/2017

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{F 431}	Continued From page 18 document review, and clinical record review, the facility staff failed to date medications (multi-dose insulin and eye drops) when opened for 2 of 15 residents in the survey sample, (Resident #114 and Resident #115). 1. The facility staff failed to date a multi-dose vial of Novolog insulin when opened for Resident #114. 2. The facility staff failed to date a bottle of eye drops when opened for Resident #115. The findings include: 1. The facility staff failed to date a multi-dose vial of Novolog insulin when opened for Resident #114. During a walk-through of the facility on 1/10/17 at 4:30 p.m., the surveyor checked the medication room on unit 1 and both medication carts. The surveyor observed a multi-dose vial of Novolog 100 unit insulin with Resident #114's name on the label in medication cart #1. The bottle of insulin had been opened. The bottle of Novolog U100 did not have a date when the vial was opened. The unit manager licensed practical nurse (L.P.N.) #7 was with the surveyor when this observation was made. L.P.N. # 7 stated "We are to date vials when opened." The unit manager stated the bottle of insulin had been delivered on 1/4/17 and she had checked all the insulins up to today 1/10/17. L.P.N. #7 stated she would find out which nurse had opened the insulin without dating the bottle. The surveyor requested the facility policy on	{F 431}	4. An audit of all insulin vials and eye drops will be conducted weekly for 4 weeks, then monthly for 2 months and/or 100% compliance by the Unit Managers. The results of the audits will be presented monthly by the Director of Nursing to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Unit Managers, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.	01/27/2017

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dating and labeling medications from corporate RN (registered nurse) #3 on 1/11/17 at 7:55 a.m.

The surveyor reviewed the facility policy titled "5 3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" on 1/11/17 The policy read in part "5. Once a medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened."

The surveyor requested the package insert for Novolog from the director of nursing and the corporate registered nurses #3 and #4 on 1/11/17 at 10 25 a.m. The director of nursing stated the medication should be discarded after 28 days A review of the package insert for Novolog read in part under how to store Novolog "The Novolog® FlexTouch®Pen you are using should be thrown away after 28 days, even if it still has insulin left in it."

The surveyor informed the administrative staff of the above concern during a meeting on 1/11/7 at 11 25 a.m. Both the director of nursing and the corporate registered nurse stated they would expect nurses to date vials of insulin when opened.

No further information was provided to the surveyor prior to the exit conference on 1/11/17.

Resident #114 was admitted to the facility 11/2/16 with diagnoses that included metabolic encephalopathy, vascular dementia, chronic

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NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF ABINGDON		STREET ADDRESS, CITY, STATE, ZIP CODE 600 WALDEN ROAD ABINGDON, VA 24210	

(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 431}	Continued From page 20 kidney disease, Type 2 diabetes mellitus, atherosclerotic heart disease, gout, hypertension, anxiety, benign prostatic hypertrophy, stage 1 pressure ulcer right heel, constipation, cardiac pacemaker, and muscle wasting. Resident #114's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/30/16 assessed the resident with a brief interview for mental status as 7 out of 15 in Section C Cognitive Summary. No signs of delirium, psychosis or behaviors were assessed. January 2017 physician order sheet revealed Resident #114 had current physician orders for Novolog 100 unit/ml (milliliter) vial Give 5 unit subcutaneously three times a day before meals and Novolog 100 unit/ml inject subq (subcutaneously) 0-50=See prn (whenever necessary) Glucagon order 51-70=See prn orders 71-150=No Ix (treatment) 151-200=2 units, 201-250=3 units; 251-300=4 units; 301-350=5 units, 351-450=9 units and recheck blood sugar in 2 hrs (hours) if still over 350 notify MD (medical doctor) above 450=notify MD. Resident #114 was administered Novolog 3 units on 1/10/17 at 4:30 p.m. for blood sugar of 201 and Novolog 5 units was scheduled with meals and administered on 1/10/17 at 4:30 p.m. and 1/11/17 at 6:00 a.m. 2. The facility staff failed to date a bottle of eye drops when opened for Resident #115. The surveyor checked the medication room and the two medication carts on unit 2 on 1/10/17 at	{F 431}		01/27/2017

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NAME OF PROVIDER OR SUPPLIER: GRACE HEALTHCARE OF ABINGDON		STREET ADDRESS, CITY, STATE, ZIP CODE: 600 WALDEN ROAD, ABINGDON, VA 24210	

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{F 431}	Continued From page 21 4:45 p.m. Unit 2 medication cart #1 was checked with licensed practical nurse (LPN) #3. During the observation, the surveyor observed an opened bottle of Pazeo 0.7% eye drops ordered for Resident #115. There was no date on the open bottle of Pazeo eye drops. LPN # 3 stated "We are to date bottles when opened." The clinical record of Resident #115 was reviewed 1/11/17. Resident #115 was admitted 3/13/14 with diagnoses that included but not limited to glaucoma, chronic obstructive pulmonary disease, depressive disorder, hyperlipidemia, insomnia, constipation, chronic kidney disease, Type 2 diabetes mellitus, dementia without behavioral disturbances, and hypertension. Quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/25/16 assessed the resident with a cognitive summary score of 15 out of 15. No signs of delirium, behaviors, or psychosis were assessed. January 2017 physician orders included the order for Pazeo 0.7% eye drops: both eyes once daily. The medication had been administered daily from 1/1/17 through 1/10/17. The surveyor requested the facility policy on dating and labeling medications from the corporate registered nurse on 1/11/17 at 7:55 a.m. The surveyor requested the package insert for Pazeo from the director of nursing and the corporate registered nurses #3 and #4 on 1/11/17 at 10:25 a.m. The surveyor reviewed the facility policy titled "5.3	{F 431}		01/27/2017

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{F 431}	Continued From page 22 Storage and Expiration of Medications, Biologicals, Syringes and Needles" on 1/11/17. The policy read in part "5. Once a medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened." The package insert for Pazeo eye drops was reviewed 1/11/17. The insert did not specify when to discard the medications only to store at 2 degrees C (Celsius) to 25 degrees C [36 degrees F (Fahrenheit) to 77 degrees F]. Keep bottle tightly closed when not in use. The surveyor informed the administrative staff of the above concern during a meeting on 1/11/7 at 11:25 a.m. Both the director of nursing and the corporate registered nurse stated they would expect nurses to date bottles of medications when opened. No further information was provided to the surveyor prior to the exit conference on 1/11/17.	{F 431}		01/27/2017
{F 514} SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented, readily accessible; and systematically organized. The clinical record must contain sufficient	{F 514}		

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information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 3 of 15 Residents in the survey sample, Resident #106, #110, and #111.

1. For Resident #106, the facility failed to ensure the residents novolog insulin orders were transcribed correctly onto the POS (physician order sheet) in the paper clinical record.

2. Resident #110 had documentation in the departmental notes of another resident's medical information.

3. The facility staff failed to ensure a complete and accurate December 2016 and January 2017 physician order sheets (POS) for Resident #111. The order for a long handled fork was discontinued on 11/8/16 but remained on both the December 2016 POS and January 2017 POS.

The findings included.

1. For Resident #106, the facility failed to ensure the Residents novolog insulin orders were transcribed correctly onto the POS in the paper clinical record. The facility nursing staff had incorrectly transcribed the Residents insulin orders to read that the resident should be

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1. Resident #106 Novolog insulin order was transcribed correctly on 1/11/17 by the Unit Manager.

   Resident #110 departmental note was updated with an addendum noting it was documented in error by the Unit Manager on 1/25/17.

   Resident #111 had the long handed flexible fork order removed from the Physician Order Summaries for November, 2016 and December, 2016 by the Unit Managers on 1/11/17.

2. All Sliding Scale order texts were audited on 1/11/17 by the Unit Managers. Issues identified were addressed.

   All Physician Order Summaries with adaptive eating devices were audited 1/25/17 – 1/27/17 by the Unit Managers. No other issues identified.

   All resident tray cards with adaptive eating devices were audited by the Dietary Manager on 1/25/17. No other issues were identified.

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administered 5 units of novolog insulin for a blood sugar of 201-350, when in fact it should have read for a blood sugar of 301-350.

The record review revealed that Resident #106 had originally been admitted to the facility 09/17/13. Diagnoses included, but were not limited to, diabetes, chronic pain, hypertension, and post-traumatic stress disorder.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/20/16 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points Section I (active diagnoses) included an active diagnosis of diabetes. Section N (medications) was coded to indicate Resident #106 received insulin 7 out of 7 days.

The Residents CCP (comprehensive care plan) included the problem area of diabetes.

The Residents clinical record included a physician signed POS (physician order summary) that included an order for novolog insulin per sliding scale for a BS (blood sugar) of 151-200 administer 2 units, 201-250 3 units, 251-300 4 units, 201-350-5 units, 351-450 9 units and recheck in 2 hours if still over 350 notify MD.

On 01/10/17 at approximately 2:55 p.m. the nurse consultant was made aware of the conflicting orders regarding the BS readings of 251-300 and 201-350. After reviewing the order with the surveyor the nurse consultant stated that they used a prepopulated order for this physician for blood sugars, the nurse that had put the order into the computer (this order was entered

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3. Licensed Nurses were in-serviced from 1/11/17 – 1/25/17 on sliding scale order text accuracy, Physician Order Summary Accuracy by the Director of Nursing and the Assistant Director of Nursing.
The Dietary Manager was in-serviced on 1/25/17 by the Director of Nursing on tray card accuracy.

4. An audit of all sliding scale order texts, Physician Order Summaries related to adaptive eating devices, and tray cards with adaptive eating devices will be audited weekly for 4 weeks, then monthly for 2 months and/or 100% compliance by the Unit Managers. The results of the audits will be presented monthly by the Director of Nursing to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Unit Managers, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
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correctly) had transposed the order incorrectly (onto the POS in the paper record) and that the 201-350 should actually read 301-350.

The nurse consultant provided the surveyor with a copy of this physician's sliding scale order and a copy of what the nurses would have used to administer the insulin. This order was as follows for a BS reading of 251-300 administer 4 units for a BS reading of 301-350 administer 5 units.

A review of the Resident's BS from 12/09/16 until the time of the survey revealed that the facility nursing staff had been administering the correct amount of insulin.

The administrative staff were made of the inaccurate clinical record in regards to insulin during a meeting with the survey team on 01/11/17 at approximately 11:25 a.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. The facility staff failed to ensure a complete and accurate clinical record for Resident #110. Resident #110 had documentation in the departmental notes of another resident's medical information.

Resident #110 was admitted to the facility 5/9/11 and readmitted 4/1/14 with diagnoses that included but not limited to chronic obstructive pulmonary disease (COPD), heart failure, atherosclerotic heart disease, dementia with behavioral disturbances, depressive disorder, peripheral vascular disease, and gastroesophageal reflux disease.

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Resident #110's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/24/16 assessed the resident with short term memory problems, long term memory problems, and severely impaired cognitive skills for daily decision making.

The surveyor reviewed Resident #110's nurse's notes (departmental notes) from 12/9/16 through 1/10/17. The Departmental Note written 1/3/17 12:44 a.m. read "BP (blood pressure) 104/52, P (pulse) 56, T (temperature) 97.8 R (respirations) 18 O2 (oxygen saturation) 96%. Continues on Doxycycline for cellulitis with no adverse effects. Will continue to monitor Call light in reach."

The surveyor reviewed the January 2017 physician orders. Resident #110 did not have current orders for Doxycycline and had no diagnosis of cellulitis.

The surveyor made the director of nursing aware of the documentation error on 1/11/17 at 8:30 a.m. After reviewing the note, the DON stated the licensed practical nurse had documented in the wrong chart.

The surveyor informed the administrative staff of the above concern in documentation in the meeting held 1/11/17 at 11:25 a.m. and requested the facility policy on documentation on 1/11/17 at 3:45 p.m.

The surveyor reviewed the facility policy on documentation titled "Charting and Documentation; Nurse's Notes" on 1/11/17. The policy read in part "Policy To maintain a complete account of the resident's care, treatment,

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response to the care, signs, symptoms, etc., as well as the progress of the resident's care. To provide caregivers with clear, concise guidelines for documentation of assessments and care given."

No further information was provided prior to the exit conference on 1/11/17.

3. The facility staff failed to ensure a complete and accurate December 2016 and January 2017 physician order sheets (POS) for Resident #111. The order for a long handled fork was discontinued on 11/8/16 but remained on both the December 2016 POS and January 2017 POS.

The clinical record of Resident #111 was reviewed 1/10/17 and 1/11/17. Resident #111 was admitted to the facility 7/4/16 and readmitted 10/22/16 with diagnoses that included but not limited to fusion of spine, cervicothoracic region, chronic obstructive pulmonary disease, lymphoid leukemia, and rheumatoid arthritis

Resident #111's fourteen (14) day minimum data set (MDS) with an assessment reference date of 11/4/16 assessed the resident with a cognitive summary score of 15 out of 15, indicating the resident was cognitively intact with no signs of delirium, psychosis, or behaviors. Resident #111 was assessed with limited range of motion on both upper extremities.

The December 2016 physician orders and the January 2017 physician orders were reviewed 1/10/17. Resident #111 had orders to use a long handed flexible fork with meals. Order date was 10/26/16.

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The surveyor observed Resident #111 on 1/11/17 at 7:30 a.m. Resident #111 was in bed, with the head of the bed elevated, eating cereal. Resident #111 was noted to have regular utensils on her tray and was using a regular spoon to eat the cereal. The resident was asked about the use of the long handed flexible fork. The resident stated she hadn't used that fork for a while. The surveyor reviewed the meal ticket. Under devices, there was nothing listed. The surveyor discussed the current physician order with licensed practical nurse (L.P.N.) #4 on 1/11/17 at 7:40 a.m. L.P.N. #4 stated she would tell rehab (rehabilitation) that Resident #111 did not have a long handled flexible fork for her meals.

The surveyor informed the unit manager licensed practical nurse #5 on 1/11/17 at 8:15 a.m. of the current physician order for the long handled flexible fork.

The director of nursing provided the surveyor with an order dated 11/8/16 that read "D/C (discontinue) long handled fork per patient request." The director of nursing stated on the December 2016 POS and the January 2017 POS; the orders for the long handled flexible fork need to be removed.

The surveyor informed the administrative staff of the above documentation concern in a meeting on 1/11/17 at 11:25 a.m. The surveyor requested a copy of the facility policy on documentation on 1/11/17 at 3:45 p.m.

The surveyor reviewed the facility policy on documentation titled "Charting and Documentation; Nurse's Notes." The policy read in part "Policy To maintain a complete account of

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