State of Virginia

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495300 | A. BUILDING _____ B. WING _____ | 12/02/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HERITAGE HALL KING GEORGE | 10051 FOXES WAY KING GEORGE, VA 22485 |

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| F 000 | Initial Comments<br><br>An unannounced Medicare/Medicaid standard survey and biennial licensure survey was conducted 11/29/16 through 12/2/16. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey.<br><br>The census in this 130 certified bed facility was 94 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Residents #1 through #16 and #20) and 3 closed record reviews (Residents #17 through #19). | F 000 | | |
| F 001 | Non Compliance<br><br>The facility was out of compliance with the following state licensure requirements:<br><br>This RULE: is not met as evidenced by:<br>The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities:<br><br>12 VAC 5-371-220 Nursing Services<br>12 VAC 5-371-220 C. Abuse<br><br>12 VAC 5-371-110 Management and Administration<br>12 VAC 5-371-110 (B.1-3, C) Cross Reference to F225<br><br>12 VAC 5-371-250 Resident Assessment and Care Plan<br>12 VAC 5-371-250 (B.3) Cross Reference to F275<br><br>12 VAC 5-371-250 Resident Assessment and Care Plan | F 001 | **F001**<br>**12 VAC 5-371-220 Nursing Services**<br>**12 VAC 5-371-220 C. Abuse**<br>**Cross Reference to F223**<br><br>Cross Reference to POC for F223<br><br>**12 VAC 5-371-110 Management and Administration**<br>**12 VAC 5-371-110 (B. 1-3, C) Cross Reference to F225**<br><br>Cross Reference to POC for F225<br><br>**12 VAC 5-371-250 Resident Assessment and Care planning**<br>**12 VAC 5-371-250 (B.3) Cross Reference to F275**<br><br>Cross Reference to POC for F275<br><br>**12 VAC 5-371-250 Resident Assessment and Care planning**<br>**12 VAC 5-371-250 (A) Cross Reference to F278** | |

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

Administrator RECEIVED 12-15-16



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| F 001 | Continued From Page 1<br><br>12 VAC 5-371-250 (A) Cross Reference to F278<br><br>12 VAC 5-371-200 Nursing Director<br>12 VAC 5-371-200 (B) Cross Reference to F281<br><br>12 VAC 5-371-220 Nursing Services<br>12 VAC 5-371-220 (A, B) Cross Reference to F323<br><br>12 VAC 5-371-220 Nursing Services<br>12 VAC 5-371-220 (B) Cross Reference to F333<br><br>12 VAC 5-371-340 Dietary and Food Service Program<br>12 VAC 5-371-340 (D) Cross Reference to F367<br><br>12 VAC 5-371-180 Infection Control<br>12 VAC 5-371-180 (C) Cross Reference to F441<br><br>12 VAC 5-371-310 Diagnostic Services<br>12 VAC 5-371-310 (A, B) Cross Reference to F502<br><br>12 VAC 5-371-360 Clinical Records<br>12 VAC 5-371-360 (E.4) Cross Reference to F514<br><br>COV 32.1-126.01<br><br>Based on employee record review, facility documentation review, and staff interview, the facility staff failed to obtain a sworn statement or criminal record check for one employee (EMP. 25) in an employee record sample of 25 employees.<br><br>For EMP. 25, the facility staff failed to obtain a criminal record check within 30 days of hire and failed to obtain a sworn statement prior to or at the time of hire.<br><br>The findings included: | F 001 | Cross Reference to POC for F278<br><br>**12 VAC 5-371-200 Nursing Director**<br>**12 VAC 5-371-200 (B) Cross Reference to F281**<br><br>Cross Reference to POC for F281<br><br>**12 VAC 5-371-220 Nursing Services**<br>**12 VAC 5-371-220 (A, B) Cross Reference to F323**<br><br>Cross Reference to POC for F-323<br><br>**12 VAC 5-371-220 Nursing Services**<br>**12 VAC 5-371-220 (B) Cross Reference to F333**<br><br>Cross Reference to POC for F-333<br><br>**12 VAC 5-371-180 Infection Control**<br>**12 VAC 5-371-180 (C) Cross Reference to F441**<br><br>Cross Reference to POC for F441<br><br>**12 VAC 5-371-310 Diagnostic Services**<br>**12 VAC 5-371-310 (A, B) Cross Reference to F502**<br><br>Cross Reference to POC for F502<br><br>**12 VAC 5-371-360 Clinical Records**<br>**12 VAC 5-371-360 (E.4) Cross Reference to F514**<br><br>Cross Reference to POC for F514 | |



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| F 001 | Continued From Page 2<br><br>EMP. 25, a CNA (certified nursing assistant) was hired 12/8/15. Review of the employee record revealed no criminal records check or sworn statement were present within the employee record.<br><br>When interviewed, EMP. B, human resources manager, stated 12/1/16 at 3:19 p.m., at the time of EMP. 25's hire, the facility was using a private company to hire staff. Part of the process of the company was to do any background or tasks related to hiring the staff including criminal back ground checks and obtaining sworn statements. EMP. B said the facility realized the company was not performing the necessary regulatory tasks and the company was not used any more for hiring.<br><br>Review of the facility's policy entitled "Guidelines for the Prevention of Abuse" included:<br><br>"5. Sworn Disclosure statements and Criminal background checks for all new employees prior to employment."<br><br>The administrator, DON (director of nursing) and ADON (assistant DON) were informed of the failure of the staff to obtain a sworn statement and criminal background check prior to or within 30 days of hire for EMP. 25, 12/1/16 at end of day meeting.<br><br>12 VAC 5 371-210 Nursing Staffing<br>12 VAC 5 371-210 E<br><br>Based on employee record review, facility documentation review, and staff interview, the facility staff failed to verify licensure with DHP (Department of Health Professions) for two employees (EMP. 8 and 18) in a survey sample of 19 licensed/certified employees. | F 001 | **POC for COV 32.1-126.01**<br>**Corrective Action(s):**<br>The facility has obtained a sworn disclosure statement and criminal background check for EMP #25 identified in the survey. An incident & accident form has been completed for this incident.<br><br>**Identification of Deficient Practices & Corrective Action(s):**<br>All other employees may have been potentially affected. The Human Resource Director will audit 100% of all active employee records to identify employees at risk. Any/all negative findings will be corrected at the time of discovery. A Risk Management Incident Accident Report will be completed for any/all negative findings.<br><br>**Systemic Change(s):**<br>The facility policy and procedure has been reviewed and no changes are warranted at this time. Administrative Staff will be inserviced and issued a copy of the policy & procedure by the Administrator and/or designee. Administrative Staff / Department Heads extending employment without meeting the requirement established by the Federal and State governments and company policy & procedure will be disciplined. Perspective employees will not be allowed to work until all required documentation has been obtained. | |



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| F 001 | Continued From Page 3<br><br>1. For EMP. #8, her license was verified with DHP the day after she was hired; and<br><br>2. For EMP. 18, the facility staff failed to verify with DHP after renewal of her license.<br><br>The findings included:<br><br>1. For EMP. #8, her license was verified with DHP the day after she was hired.<br><br>EMP. #8, an LPN (licensed practical nurse), was hired by the facility 2/20/16. Review of her employee record revealed her LPN license was verified with DHP on 2/21/16.<br><br>EMP. B, the human resources manager, stated 12/1/16 at 3:19 p.m., her practice (at the time of EMP. 8's hire) was to verify licensure with DHP on the first day of orientation. EMP. B stated she has since changed her practice to verify licensure prior to hire.<br><br>Review of the facility's policy entitled "Guidelines For the Prevention of Abuse" included:<br><br>6. License verification performed for all licensed staff prior to employment."<br><br>The administrator, DON, and ADON were informed of the failure of the staff to verify EMP. 8's license with DHP prior to hire, 12/1/16 at the end of day meeting.<br><br>2. For EMP. 18, the facility staff failed to verify with DHP after renewal of her license.<br><br>EMP. 18, an RN (registered nurse) was hired by the facility 6/3/15. Her license was initially verified with DHP and expired on 8/31/16. A thorough | F 001 | **Monitoring:**<br>The Human Resources Director is responsible for maintaining compliance. The Business Office Manager and/or designee will conduct monthly audits of employee files tool to maintain compliance. The administrator will review all audits and report aggregate findings to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice.<br>**Completion Date: 1/16/17**<br><br>**12 VAC 5-371-210 Nurse Staffing**<br>**12 VAC 5-371-210 E**<br><br>**Corrective Action(s):**<br>The facility administrator and Medical director were notified that the facility failed to verify EMP #8 & #18's license with DHP in a timely manner at the time of hire and at the time of renewal. An incident & accident form has been completed for this incident.<br><br>**Identification of Deficient Practices & Corrective Action(s):**<br>All other licensed nurses may have been potentially affected. The Business Office Manager and/or designee will audit 100%<br><br>of all active licensed nurse's employee records to identify employees at risk. Any/all negative findings will be corrected at the time of discovery. A Risk Management Incident Accident Report will be completed for any/all negative findings. | |



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| F 001 | Continued From Page 4<br><br>review of EMP. 8's employee record revealed no verification of her license after the license expired. Documentation was evident that EMP. 8 was terminated from employment on 10/31/15.<br><br>When interviewed 12/1/16 at 3:19 p.m., EMP. B stated EMP. 18 quit sometime in September, 2015. EMP. B stated she did not think EMP. 18 worked after 8/31/15 but was unable to verify that as EMP. 18 was salaried and did not have to punch a time clock. EMP. B stated she did not verify EMP. 18's license after it expired, but was uncertain why the license was not verified after renewal.<br><br>The DON stated 12/2/16 at 9:12 a.m., EMP. 18 resigned 9/8/15. The DON stated she knew that EMP. 18 worked between 8/31 and 9/8/15.<br><br>The administrator, DON, and ADON were informed of the failure of the staff to verify EMP. 18's RN license with DHP after renewal, 12/2/16 at end of day meeting. | F 001 | **Systemic Change(s):**<br>The facility policy and procedure has been reviewed and no changes are warranted at this time. The human resources department will be inserviced and issued a copy of the policy & procedure for verifying and maintaining a current copy of the nurse's current license verification from the Department of Health professions as well as current CPR certification for licensed nurses by the regional nurse consultant. Perspective employees will not be allowed to work until all required documentation has been obtained.<br><br>**Monitoring:**<br>The Human resource Manager is responsible for maintaining compliance. The Business Office Manager and/or designee will conduct monthly audits of employee files using the employee file audit tool to maintain compliance. The administrator will review all audits and report aggregate findings to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice.<br>**Completion Date:1/16/17** | |



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| F 000 | INITIAL COMMENTS | F 000 | | |

An unannounced Medicare/Medicaid standard survey was conducted 11/29/16 through 12/2/16. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey.

The census in this 130 certified bed facility was 94 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Residents #1 through #16 and #20) and 3 closed record reviews (Residents #17 through #19).

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

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**F164**
**Corrective Action:**
CNA F performing incontinence care on resident #8 was inserviced on the facility policy and procedure for providing privacy during incontinence care and ADL care.

**Identification of Deficient Practice(s) & Corrective Action(s):**
All residents receiving incontinence care may have been potentially affected. A 100% observation audit of all residents receiving incontinence care will be conducted to identify any residents at risk for the potential unnecessary exposure of their bodies during personal care and services. Any residents identified as being exposed during the audit will be corrected at time of discovery and staff involved will receive immediate inservice training. An Incident & Accident Form will be completed for any/all incidents of exposure.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | Administrator | 12-15-16 |

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<br>regardless of the form or storage method of the records, except when release is-<br><br>(i) To the individual, or their resident representative where permitted by applicable law;<br><br>(ii) Required by Law;<br><br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br><br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview, facility documentation and clinical record review, the facility staff failed for one resident, Resident #8, in a survey sample of 20 residents, to ensure the resident was provided privacy during incontinence care.<br><br>Resident #8 was exposed during incontinence care.<br><br>The findings included:<br><br>Resident # 8 was admitted to the facility on 10/11/16. Diagnoses for Resident #8 included but not limited to Hypertension, intracranial | F 164 | **Systemic Change(s):**<br>The facility policy and procedure has been reviewed and no changes are warranted at this time. All staff will be inserviced by the DON, and/or Social Services director on Resident Rights, Confidentiality and Personal Privacy to include unnecessary exposure during personal care and services.<br><br>**Monitoring:**<br>The DON is responsible for compliance. The DON, ADON and/or designee will perform two weekly incontinent care audits on each unit in order to maintain compliance. Any/all negative findings will be corrected immediately and disciplinary action will be taken as warranted. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice.<br>**Completion Date: 1/16/2017** | |



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| F 164 | Continued From page 2 | F 164 | | |

hemorrhage, lymph edema (swelling of the lower legs) and seizure disorder. Resident #8's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 10/18/16 coded Resident #8 with a BIMS (brief interview of mental status) score of "11" out of a possible 15, or minimal cognitive impairment. In addition, the Minimum Data Set coded Resident #8 requiring extensive assistance for Activities of Daily Living (ADL's) care. The resident required extensive assistance with the assistance of one staff member for toileting. She was coded as being frequently incontinent of bowel and bladder.

On 11/29/16 at 4:20 PM, Resident #8 was observed from the hallway in bed. Resident #8's door was open and the privacy curtain was pulled partway, leaving her legs and buttocks in view. The resident was in the process of receiving incontinence care. CNA (certified nursing assistant) F viewed writer and continued to provide care, not closing the curtain.

Review of Resident #8's care plan dated 10/11/16 revealed that Resident #8 had an "inability to perform ADL's" due to cerebral infarct, urinary retention, and history of stroke.

Review of the facility's policy "Quality of Life-Dignity and Privacy" read as followed: "Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care."

On 11/30/16 at 12:50 PM, an interview with Resident #8 was conducted. Resident #8 was informed that the privacy curtain was not pulled completely closed during care. She stated, "That's terrible, I want them to close the curtain."



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| F 164 | Continued From page 3<br><br>On 12/1/16 at 6:25 PM, an interview with CNA (F) was conducted. He was asked his procedure for providing incontinence care. He stated, "I knock on the door, wait and go in." He went on to say that he would introduce himself, get supplies, run the water, get soap, open brief, etc. CNA (F) was asked if pulling the privacy curtain was important; CNA (D) stated, "Yes." CNA (F) was informed the resident was exposed during care. He stated, "I saw you, I should have pulled the curtain closed."<br><br>On 12/1/16 at 6:45 PM, the Administrator and DON (director of nursing) were notified of above findings. | F 164 | | |
| F 223 SS=D | 483.12 FREE FROM ABUSE/INVOLUNTARY SECLUSION<br><br>483.12<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms.<br>This REQUIREMENT is not met as evidenced by:<br>Based on Resident interview, facility documentation review, clinical record review and staff interview, the facility staff failed to ensure one Resident (Resident #13) in a survey sample of 20 Residents was free from verbal abuse.<br><br>Resident #13 was verbally abused by Resident #14, who stated "I'm going to (f**k) you and subsequently felt afraid of Resident #14. | F 223 | **F223**<br>**Corrective Action(s):**<br>Alternate placement is being investigated for Resident #14 at a facility more suitable manage his behaviors.<br><br>Resident's #13has been reassessed by their attending physician, Mental Health services, and the Interdisciplinary Care planning team to establish interventions to be implemented to prevent them from any further potential verbal or physical abuse from resident #14 or any other residents. | |



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| F 223 | Continued From page 4<br>The findings included:<br><br>Resident #13, a female, was admitted to the facility 5/1/13 and readmitted after a hospitalization 4/10/16. Her diagnoses included osteoporosis, history of breast cancer, elevated cholesterol, deep vein thrombosis, nonrheumatic aortic valve disorder, hypertension, type II diabetes mellitus, contact dermatitis, muscle weakness, cardiac arrhythmia, and contractures.<br><br>Resident #13's most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/15/16 was coded as a quarterly assessment. Resident #13 was coded as having some short and long term memory deficits and required moderate assistance with making every day life decisions. Resident #13 was coded as requiring extensive to total assistance with performing her activities of daily living.<br><br>Resident #14, a male, was admitted to the facility 4/1/16. His diagnoses included failure to thrive, diabetes mellitus, arteriosclerotic cardiovascular disease, depressive disorder with severe psychiatric symptoms, cerebral infarction, and chronic obstructive pulmonary disease.<br><br>Resident #14's most recent MDS with an ARD of 9/28/16 was coded as a quarterly assessment. Resident #14 was coded as having some short and long term memory deficits and required moderate assistance with making daily life decisions. He was coded as having no behaviors during the look back period. Resident #14 was coded as requiring extensive to total assistance of one to two staff members to perform his activities of daily living with the exception of eating. For eating Resident #14 was coded as | F 223 | **Identification of Deficient Practice(s) & Corrective Action(s):**<br>All residents may potentially be affected. The last 3 months or resident council minutes and the last 60 days of reported resident to resident altercations will be reviewed by the administrator to identify any residents at risk. Any/all residents identified will immediately be investigated to determine if interventions are required to prevent and protect residents from future verbal or physical abuse. All incident & accident forms for the past 60 days will be reviewed by the Administrator for any incidents of verbal or physical abuse. Any/all findings will be reviewed for proper reporting and proper interventions put in place and all negative findings will be reported to the appropriate state agency, attending physician, and the responsible party. A facility incident & accident form will be completed for each negative finding. | |

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| F 223 | Continued From page 5<br>needing supervision.<br><br>During the Group interview, 11/30/16 at 1:30 p.m., Resident #14 stated "there was someone that wandered in my bedroom and said terrible things to me. I asked if he was still here and no one will tell me if he is." Review of the Group minutes for August 2, 2016, revealed Resident #13 stated she was afraid of one of the Residents due to his wandering in and out of Resident bedrooms. The Resident that was wandering was identified as Resident #14.<br><br>During an interview, Resident #13 stated she had told the staff she was afraid of Resident #14 after he wandered into her bedroom. She was unable to remember exactly when the incident had occurred however it was "couple of months" ago. Resident #13 stated she was in bed and Resident #14 wandered into her room and stated "I am going to (f**k) you". Resident #13 stated it startled her and she told him to leave her bedroom. Resident #14 left her room. Resident #13 stated she did not recall if she told the staff at the time of the incident but the Resident council meeting was shortly after that and she told the activities director during the meeting.<br><br>Resident #13 stated Resident #14 would wander in and out of other Resident bedrooms and other Residents had told her they were concerned about Resident #14. Resident #13 stated she had not seen Resident #14 at the facility recently and "they (administration) won't tell me if he is still here." She further stated the staff told her "he (Resident #14) has rights also."<br><br>Resident #13 stated other than Resident #14 she was not afraid at the facility and that no one else | F 223 | **Systemic Change(s):**<br>The facility Policy and Procedure for reporting and preventing resident abuse has been reviewed and no changes are warranted at this time. The administrative staff will be inserviced by the administrator on the Policy and Procedure for reporting and preventing abuse and will be given a copy. All staff members will be inserviced and given a copy of the Abuse reporting and prevention policy and procedure by the Administrator. The inservices provided will include information on the procedure for reporting incidents of abuse, both verbal and physical, interventions and monitoring techniques for residents who are acting out verbally and physically, and notification to responsible party, attending physician as state agencies per policy and procedure. | |



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| F 223 | Continued From page 6<br>had every tried to hurt her.<br><br>Review of Resident #13's clinical record revealed no psychosocial concerns were identified for Resident #13. Resident #13 had been evaluated and was being followed by psychological services prior to the incident and review of the notes since August, 2016 revealed no concerns regarding Resident #13 being afraid.<br><br>During abuse interviews with five staff members, all of the staff stated they were to report any incidents of abuse to their supervisor immediately and to keep their Residents "safe."<br><br>Review of Resident #14's clinical record revealed, from the time of his admission, he had a history of wandering around the facility, including in Resident's bedrooms. No other incidents of Resident to Resident interactions were noted with the exception of Resident #14 hitting one of the Residents foot with his wheelchair.<br><br>When interviewed, Other C, the activities director, 12/2/16 at 8:30 a.m., stated she let the managers know of any concerns that are identified during the Resident council meetings. Other C stated she completed a form regarding the concerns voiced on 8/2/16.<br><br>The form, entitled "Resident Grievance/Complaint Form", only included "Resident in others rooms taking their personal items. What is being done to prevent this from happening?" Nothing was included in the communication form indicating Resident #13 was afraid of Resident #14.<br><br>Review of the facility's policy entitled "Abuse Prohibition, Identification, Investigation/Protection | F 223 | **Monitoring:**<br>The administrator and DON are responsible for compliance. All Facility Incident & Accident Forms will be reviewed by the Administrator and DON and initialed as reviewed. All reported incidents of abuse will be investigated and reported to the appropriate state agencies by the Administrator. Confidential files of reported incidents and all follow up documentation will be maintained in the Administrator's office. The Incident and Accident tracking log will be reviewed weekly in the Risk Management meeting to monitor for compliance. All negative findings will be reported to the administrator for investigation and reported to the appropriate state agencies. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice.<br>**Completion Date: 1/16/17** | |

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| F 223 | Continued From page 7<br>And Reporting," included:<br><br>"Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members, legal guardians, friends or other individuals."<br><br>The administrator stated 12/2/16 at 9:20 a.m., the concern identified in Resident council by Resident #13 regarding Resident #14 was not identified, as the appropriate information was not written on the Grievance form. The administrator stated after concerns were identified regarding Resident #14, the facility developed interventions that included referral to psychologist, offering Residents "stop signs" for their doors, every 15 minute checks, and care plan meeting with Resident #14's family to attempt to find a more suitable placement.<br><br>The administrator, DON (director of nursing), and ADON (assistant director of nursing) were informed of the failure of the staff to ensure Resident #13 was not subjected to verbal abuse resulting in her fear, 12/2/16 at 12/1/16 at end of day meeting. | F 223 | | |
| F 225 SS=D | 483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>(a) The facility must-<br><br>(3) Not employ or otherwise engage individuals who-<br><br>(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or | F 225 | **F-225**<br>**Corrective Action(s)**<br>A thorough investigation into the allegations of verbal abuse involving resident'#14 against resident #13 has been conducted and the outcome of the internal investigations have been reported to the appropriate State agencies. | |



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| F 225 | Continued From page 8<br>mistreatment by a court of law;<br><br>(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or<br><br>(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.<br><br>(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.<br><br>(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. | F 225 | **Identification of Deficient Practices & Corrective Action(s):**<br>All residents to include may have been potentially affected. A 100% review of all resident council minutes for the last 3 months and the Facility Incident & Accident Forms for the previous 60 days have been reviewed to identify residents at risk. Any/all negative findings of reportable occurrences identified will result in an internal investigation with appropriate notification of outcomes to the State agencies, attending physician and responsible parties.<br><br>**Systemic Change(s):**<br>Policy and Procedure for reporting resident abuse & neglect has been reviewed. No changes are required. All administrative staff will be inserviced on the facility policy and procedures regarding reporting, investigation and proper notification to state agencies of allegations of verbal or physical abuse and injuries of unknown origin by the administrator. All staff will be inserviced on the facility policy and procedures regarding reporting, investigation and proper notification to state agencies of allegations of verbal or physical abuse and injuries of unknown origin by the Administrator. The Administrator, DON and/or designee is responsible for completing internal investigations of neglect, abuse, and/or complaints. The Administrator will review all findings and verify that the appropriate notification to the RP, attending physician and State agencies was completed as indicated. | |

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| F 225 | Continued From page 9 | F 225 | **Monitoring:** The Administrator is responsible for maintaining compliance. Facility Incident & Accidents forms will be reviewed daily by the DON and/or Administrator and initialed as reviewed. Confidential files of reported incidents and all follow-up documentation will be maintained in the Administrator's office. The Risk Management Committee will review I&A Reports for identifying and/or correcting negative patterns weekly. All negative findings will be reported and investigated. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date: 1/16/17** | |

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

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

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on Resident interview, facility documentation review, clinical record review, and staff interview, the facility staff failed to report an allegation of verbal abuse for one Resident (Resident #13) in a survey sample of 20 Residents.

Resident #13 reported she was afraid of Resident #14 to the activities director and the allegation was not reported to the administrator.

The findings included:

Resident #13, a female, was admitted to the facility 5/1/13 and readmitted after a hospitalization 4/10/16. Her diagnoses included osteoporosis, history of breast cancer, elevated cholesterol, deep vein thrombosis, nonrheumatic aortic valve disorder, hypertension, type II diabetes mellitus, contact dermatitis, muscle weakness, cardiac arrhythmia, and contractures.

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| F 225 | Continued From page 10 | F 225 | | |

Resident #13's most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/15/16 was coded as a quarterly assessment. Resident #13 was coded as having some short and long term memory deficits and required moderate assistance with making every day life decisions. Resident #13 was coded as requiring extensive to total assistance with performing her activities of daily living.

Resident #14, a male, was admitted to the facility 4/1/16. His diagnoses included failure to thrive, diabetes mellitus, arteriosclerotic cardiovascular disease, depressive disorder with severe psychiatric symptoms, cerebral infarction, and chronic obstructive pulmonary disease.

Resident #14's most recent MDS with an ARD of 9/28/16 was coded as a quarterly assessment. Resident #14 was coded as having some short and long term memory deficits and required moderate assistance with making daily life decisions. He was coded as having no behaviors during the look back period. Resident #14 was coded as requiring extensive to total assistance of one to two staff members to perform his activities of daily living with the exception of eating. For eating Resident #14 was coded as needing supervision.

During the Group interview, 11/30/16 at 1:30 p.m., Resident #14 stated "there was someone that wandered in my bedroom and said terrible things to me. I asked if he was still here and no one will tell me if he is." Review of the Group minutes for August 2, 2016, revealed Resident #13 stated she was afraid of one of the Residents due his wandering in and out of Resident bedrooms. The Resident that was wandering was identified as

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Resident #14.

During an interview, Resident #13 stated she had told the staff she was afraid of Resident #14 after he wandered into her bedroom. She was unable to remember exactly when the incident had occurred however it was "couple of months" ago. Resident #13 stated she was in bed and Resident #14 wandered into her room and stated "I am going to (f**k) you". Resident #13 stated it startled her and she told him to leave her bedroom. Resident #14 left her room. Resident #13 stated she did not recall if she told the staff at the time of the incident but the Resident council meeting was shortly after that and she told the activities director during the meeting.

Resident #13 stated Resident #14 would wander in and out of other Resident bedrooms and other Residents had told her they were concerned about Resident #14. Resident #13 stated she had not seen Resident #14 at the facility recently and "they (administration) won't tell me if he is still here." She further stated the staff told her "he (Resident #14) has rights also."

During abuse interviews with five staff members, all of the staff stated they were to report any incidents of abuse to their supervisor immediately and to keep their Residents "safe."

Review of Resident #14's clinical record revealed, from the time of his admission, he had a history of wandering around the facility, including in Resident's bedrooms. No other incidents of Resident to Resident interactions were noted with the exception of Resident #14 hitting one of the Residents foot with his wheelchair.

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| F 225 | Continued From page 12 | F 225 | | |

When interviewed, Other C, the activities director, 12/2/16 at 8:30 a.m., stated she let the managers know of any concerns that are identified during the Resident council meetings. Other C stated she completed a form regarding the concerns voiced on 8/2/16.

The form, entitled "Resident Grievance/Complaint Form", only included "Resident in others rooms taking their personal items. What is being done to prevent this from happening?" Nothing was included in the communication form indicating Resident #13 was afraid of Resident #14. Other C stated she did not know why she did not report that Resident #13 was afraid of Resident #14. Other C stated she completed the form and gave it to the administrator.

Review of the facility's policy entitled "Abuse Prohibition, Identification, Investigation/Protection And Reporting," included:

"Associates are among those who are mandated by he Code of VA, Section 63.1-55.3 to report suspected abuse, neglect, injuries of unknown origin, or mistreatment of any resident to their supervisor or an administrative staff member immediately following any alleged incident. Reports are to be made without regard to the identity of the alleged perpetrator of the abuse, neglect or mistreatment (i.e. the alleged perpetrator may be facility staff, persons visiting the facility, another resident, family member, student, volunteer, or other contractor of the facility).

1. Remove the resident from danger immediately.

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| F 225 | Continued From page 13<br>2. The Administrator and/or Director of Nursing are to be notified immediately.<br><br>3. Closely monitor and document thoroughly the behavior and condition of the resident involved to evaluate any injury.<br><br>4. Notification MUST be made to the following of all residents involved in the incident:<br>a. Attending physician<br>b. Responsible party..."<br><br>The administrator stated he was unaware that Resident #13 was afraid of Resident #14, 12/2/16 at 9:20 a.m. He stated the activities director failed to appropriately complete the Grievance form and did not include that Resident #13 was afraid of Resident #14. After other incidents involving Resident #14, and his wandering, the facility implemented a number of interventions to promote safety for the Residents at the facility.<br><br>The administrator and DON (director of nursing) were informed of the failure of the staff to report an allegation of abuse for Resident #13, 12/2/16 at end of day meeting. | F 225 | | |
| F 275 SS=D | 483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS<br><br>(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.<br><br>(iii) Not less than once every 12 months. | F 275 | **F275**<br>**Corrective Action(s):**<br>Resident #2 has had a Comprehensive Significant Change Assessment completed. Resident #2's comprehensive care plan reviewed and revised to reflect resident specific approaches and interventions to address her specific needs. | |



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| F 275 | Continued From page 14<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to complete a MDS (minimum data set) RAI (Resident assessment instrument) at least every twelve months for one Resident (Resident #2) in a survey sample of 20 Residents.<br><br>For Resident #2, no annual MDS RAI assessment was completed within 12 months of her admission, 10/23/15.<br><br>The findings included:<br><br>Resident #2, a female, was initially admitted to the facility 10/23/15. Her diagnoses included chronic congestive heart failure, arteriosclerotic cardiovascular disease, type II diabetes mellitus, hypertension, chronic kidney disease, osteoarthritis, and pruritis.<br><br>Resident #2's most recent MDS with an ARD (assessment reference date) of 10/25/16 was coded as a quarterly assessment. Resident #2 was coded as having minimal memory deficits and required minimal assistance with making daily life decisions. Resident #2 was coded as needing extensive to total assistance of one staff member to perform all of her activities of daily living with the exception of transferring and eating. For transferring she was coded as needing limited assistance of one staff and for eating she was coded as requiring supervision.<br><br>Review of Resident #2's clinical record revealed an admission assessment (with an ARD of 11/5/15) had been completed after Resident #2's admission to the facility. Since that | F 275 | **Identification of Deficient Practice and Corrective Action(s):**<br>All other residents may have potentially been affected. A 100% review of resident assessments will be done by the RCC and/or designee to ensure that all residents have had a comprehensive assessment in the last 366 days. Any/all negative findings will be reported to the resident care coordinator at time of discovery for immediate correction. Comprehensive care plans will be revised as needed to reflect resident specific measurable objectives and interventions.<br><br>**Systemic Change(s):**<br>The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The Resident Care Coordinator has read Chapter 2 of the Resident Assessment Instrument User's Manual that covers assessment scheduling and has demonstrated through discussion and written examples understanding the MDS scheduling process. All MDS' to include unscheduled, significant change and quarterly MDS's will now be reviewed each month according to the MDS calendar and initialed by the DON to ensure the accuracy and integrity of resident data. | |

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| HERITAGE HALL KING GEORGE | 10051 FOXES WAY KING GEORGE, VA 22485 |

| (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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| F 275 | Continued From page 15<br>comprehensive assessment, only quarterly assessments had been completed. No other comprehensive assessments had been completed.<br><br>Guidance is provided in "Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.14 October, 2016, page 2.21<br><br>The annual assessment is a comprehensive assessment for a Resident that must be completed on an annual basis (at least every 366 days) unless a SCSA or a SCPA (significant change) has been completed since the most recent comprehensive assessment was completed."<br><br>When interviewed LPN (licensed practical nurse) F, an MDS coordinator, stated she had missed completing an annual assessment, 11/30/16 at 11:08 a.m.<br><br>The administrator and DON (director of nursing) were informed of the failure of the staff to complete an annual MDS assessment within 12 months, 11/30/16 at end of day meeting. | F 275 | **Monitoring:**<br>The DON and RCC are responsible for compliance. An MDS audit will be conducted monthly coinciding with the MDS calendar to verify that reason for assessment is correct and was completed according to RAI guidelines. Any/all negative findings from the audit will be reported to the DON and the RCC will make corrections at the time of discovery. Aggregate findings of the audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.<br>**Completion Date:1/16/2017** | |
| F 278 SS=D | 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.<br><br>(h) Coordination<br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>(i) Certification | F 278 | **F278**<br>**Corrective Action(s):**<br>Resident #2 has had their most recent MDS modified by the MDS coordinator to accurately code section G for transfers. A facility Incident & Accident form was completed for this incident.<br><br>Resident #4 has had a modification competed to the most recent MDS to accurately code the residents medication usage in section N. A facility Incident & Accident form was completed for this incident. | |

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| | 495300 | A. BUILDING _____ B. WING _____ | 12/02/2016 |

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| F 278 | Continued From page 16<br>(1) A registered nurse must sign and certify that the assessment is completed.<br><br>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>(j) Penalty for Falsification<br>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(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<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to complete an accurate MDS (minimum data set) RAI (Resident assessment instrument) for two Residents (Resident #2 & #4 ) in a survey sample of 20 Residents.<br><br>1. For Resident #2, her ability to transfer was miscoded, while she was a Hoyer lift transfer, she was coded as needing only limited assistance of one staff member; and<br><br>2. Resident #'4's MDS (minimum data set) was | F 278 | **Identification of Deficient Practice(s) and Corrective Action(s):**<br>All other residents may have potentially been affected. A 100% audit of all current resident assessments will be completed by the MDS Coordinator and/or designee to ensure that MDS section G – Transfers and Section N – Medication are assessed and coded correctly. All negative findings will be reported to the MDS department for immediate correction. A Modification will be completed for each discrepancy identified on the most current MDS.<br><br>**Systemic Change(s):**<br>The Resident Interdisciplinary Care Team have been inserviced by the Regional Nurse consultant on the proper assessment and coding of all areas of the MDS to include sections G and N of the MDS. All comprehensive MDS's and quarterly MDS's will now be reviewed each week according to the MDS schedule by the RCC and/or DON to ensure the accuracy and integrity of resident data.<br><br>**Monitoring:**<br>The DON and RCC are responsible for monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS calendar to monitor for compliance. All negative findings from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.<br>**Completion Date: 1/16/17** | |

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| F 278 | Continued From page 17 | F 278 | | |

miscoded; the resident was coded as having daily hypnotics when the resident was not on hypnotics.

The findings included:

1. For Resident #2, her ability to transfer was miscoded, while she was a Hoyer lift transfer, she was coded as needing only limited assistance of one staff member.

Resident #2, a female, was initially admitted to the facility 10/23/15. Her diagnoses included chronic congestive heart failure, arteriosclerotic cardiovascular disease, type II diabetes mellitus, hypertension, chronic kidney disease, osteoarthritis, and pruritis.

Resident #2's most recent MDS with an ARD (assessment reference date) of 10/25/16 was coded as a quarterly assessment. Resident #2 was coded as having minimal memory deficits and required minimal assistance with making daily life decisions. Resident #2 was coded as needing extensive to total assistance of one staff member to perform all of her activities of daily living with the exception of transferring and eating. For transferring she was coded as needing limited assistance of one staff and for eating she was coded as requiring supervision.

Guidance is provided in "Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.14 October, 2016, p. G-3

Transfer: How Resident moves to and from surfaces including to or from bed, chair, wheelchair, standing position (excludes to or from toilet).

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| F 278 | Continued From page 18 | F 278 | | |

p. G.5 Code Limited Assistance: If Resident was highly involved in activity and received physical assistance in guided maneuvering of limb or other non-weight bearing assistance on three or more times in the last 7 days.

Code 4-Total Assistance: if there was full staff performance of an activity with no performance by the Resident for any aspect of the ADL (activities of daily living) activity and the activity occurred three or more times..."

When interviewed LPN (licensed practical nurse) F, an MDS coordinator, stated she had miscoded the assessment 11/30/16 at 11:08 a.m. LPN F said there is no way Resident #2 could assist with her transfer with a Hoyer lift and that it took two staff for the transfer to be completed.

The administrator and DON (director of nursing) were informed of the failure of the staff to accurately code an MDS for Resident #2, 11/30/16 at end of day meeting.
2. Resident #'4's MDS (minimum data set) was miscoded; the resident was coded as having daily hypnotics when the resident was not on hypnotics.

Resident # 4 was admitted to the facility on 12/12/14. Diagnoses for Resident #4 included but not limited to Hypertension, depression, dementia and psychiatric symptoms. Resident #4's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 9/7/16 coded Resident #4 with a BIMS (brief interview of mental status) score of "0" out of a possible 15, or severe cognitive impairment. In addition, the

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| F 278 | Continued From page 19<br>Minimum Data Set coded Resident #4 as not walking in the last seven days, and used a wheelchair with limited assistance with one staff member. The resident was coded as having received hypnotics in the last seven days.<br><br>Review of the resident's MDS dated 9/7/17 and 7/17/16 revealed that on section N0410 D, the resident was documented as having received hypnotics daily for the last seven days. Review of the resident's MAR's (medication administration record) for September and July did not have these medications documented as given.<br><br>On 12/2/16 at 10:15 AM, an interview with the MDS coordinator (other D) was conducted. She stated, "It was a data entry error. She was on antipsychotics."<br><br>On 12/1/16 at 6:45 PM, the DON (director of nursing) and Administrator were notified of above findings. | F 278 | | |
| F 281 SS=D | 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>(b)(3) Comprehensive Care Plans<br><br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and clinical record review the facility staff failed for 1 resident (Resident #12) of 20 residents in the survey sample to follow professional standards of | F 281 | **F281**<br>**Corrective Action(s):**<br>Resident #12's attending physician has been notified that the facility staff failed to accurately administer an inhaler and have the resident rinse their mouth after use per physician orders. Resident #12's physician orders have been reviewed to ensure all medication orders accurate. A Facility Incident & Accident Form was completed for these incidents. | |

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| F 281 | Continued From page 20<br>nursing for medication administration.<br><br>For Resident #12, the nurse did not require the resident to rinse his mouth per physician order after the administration of Breo, an inhaler.<br><br>The findings included:<br><br>Resident #12, a 72 year old, was admitted to the facility on 3/7/16. His diagnoses included hypertension, diabetes, anxiety, anemia and wheezing.<br><br>Resident #12's most recent Minimum Data Set assessment was a 30 day assessment with an assessment reference date of 10/8/16. He was coded with a Brief Interview of Mental Status score of 12 indicating no cognitive impairment. He required extensive assistance with activities of daily living.<br><br>On 11/20/16 at 8:35 a.m., Resident #12's medication administration was observed as part of the medication pour and pass observation. Licensed Practical Nurse A (LPN A) was the nurse who prepared the medications during the observation.<br><br>Upon entering the room, LPN A administered Resident #12's pills first. Next, LPN A instructed Resident #12 take an inhalation from the Breo inhaler. Afterward, LPN A gave Resident #12 some water and instructed him to rinse. She then left the room. This surveyor stayed in the room with the resident. Resident #12 swished the water around in his mouth and then swallowed the water. LPN A did not re-enter the room.<br><br>Resident #12's physician orders, signed 11/10/16, | F 281 | **Identification of Deficient Practices/Corrective Action(s):**<br>All other residents may have been potentially affected. The DON, ADON and/or designee will conduct a 100% review of all resident's medication orders to identify any residents at risk. All residents identified at risk will be corrected at time of discovery and an Incident & Accident form will be completed for each negative finding. The attending physicians will be notified of each incorrect medication order.<br><br>**Systemic Change(s):**<br>The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of care which includes, obtaining, transcribing and administering physician ordered medications and treatments per physician order. Licensed staff will be inserviced by the DON and/or regional nurse consultant on the policy & procedure for medication administration to include pre and post administration instructions. | |

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| F 281 | Continued From page 21<br>were reviewed. Included was an order for Breo Ellipta 100-25 microgram inhale 1 inhalation every day for wheezing "rinse mouth after each use".<br><br>On 11/30/16 at 11:15 a.m., the medication pour and pass observation was reviewed with LPN A. When asked what was supposed to happen after the administration of the Breo inhaler, LPN A stated the resident needed to rinse. When asked what was supposed to happen after the rinse, LPN A stated that the resident needed to spit out the water. It was reviewed with LPN A that after she gave Resident #12 water to rinse, she left the room and did not return. It was reviewed that the resident swallowed the water after he rinsed.<br><br>Fundamentals of Nursing, 6th Edition, Potter-Perry, p. 841, provides the following guidance for standards of medications administration " To ensure safe medication administration the nurse should be aware of a nursing standard called the six rights of medication administration. All medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:<br>1. The right medication<br>2. The right dose<br>3. The right client<br>4. The right route<br>5. The right time<br>6. The right documentation"<br><br>The issue with the Breo inhaler administration was reviewed with the Director of Nursing and Administrator at the end of day meeting on 11/30/16. The Director of Nursing stated that the | F 281 | **Monitoring:**<br>The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Manager will review medication orders weekly in order to maintain compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.<br>**Completion Date: 1/16/17** | |

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| F 281 | Continued From page 22<br>facility used Lippincott as their nursing standard reference. | F 281 | | |
| F 309 SS=D | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>483.24 Quality of life<br>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.<br><br>483.25<br>(k) Pain Management.<br>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.<br><br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and clinical record review the facility staff failed for 1 resident (Resident #1) to follow physician orders.<br><br>1. For Resident #1, the facility failed to administer Norvasc (for blood pressure) according to physician ordered parameters. | F 309 | **F309**<br>**Corrective Action(s):**<br>Resident #1's attending physician was notified that the facility staff failed to administer Norvasc according to physician parameters as ordered by the physician. A facility Incident and Accident form was completed for this incident.<br><br>**Identification of Deficient Practices/Corrective Action(s):**<br>All other residents may have been potentially affected. The DON, ADON, and Unit Managers will conduct a 100% audit of all resident's physician orders and MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. | |

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| F 309 | Continued From page 23 | F 309 | | |

The findings included:

1. For Resident #1, the facility failed to administer Norvasc (for blood pressure) according to physician ordered parameters.

Resident #1, a 90 year old, was admitted to the facility on 6/12/15. Her diagnoses included hypertension, congestive heart failure, dementia, chronic obstructive pulmonary disease, dysphagia and depression.

Her most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 9/29/16. She had a Brief Interview of Mental Status score of 6 indicating severe cognitive impairment. She required assistance with her activities of daily living.

Resident #1's physician orders signed on 11/8/16 were reviewed. Included was an order for Norvasc 5 milligram tablet, one tablet by mouth daily if systolic blood pressure is greater than 160 or diastolic blood pressure is greater than 90.

The November 2016 Medication Administration Record (MAR) was reviewed. Blood pressures were documented in the Norvasc administration box. The following blood pressures, which met the parameters for administration, were documented on the MAR. Norvasc should have been administered on these days but was not administered:

11/8/16: 169/73
11/13/16: 162/71
11/16/16: 161/74
11/20/16: 173/80

**Systemic Change(s):**
The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician orders, medication orders, treatment orders. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. As well as following physician ordered parameters for administration.

**Monitoring:**
The DON will be responsible for maintaining compliance. The DON, and/or ADON will perform weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.
**Completion Date: 1/16/17**

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F 309 Continued From page 24
11/24/16: 172/71

F 309

On 12/1/16 at 2:00 p.m., Licensed Practical Nurse A (LPN A) was working the medication cart on Resident #1's hall. LPN A was asked what the parameters on the Norvasc order meant. LPN A stated that the order said OR, so only one of the parameters needed to be met rather than both. LPN A stated that parameters were set up in the computer so that the computer would alert when the Norvasc needed to be given. It was reviewed that the medication was not given on five occasions when it should have been.

On 12/1/16 at 2:40 p.m., the issue with the Norvasc parameters was reviewed with the Director of Nursing (DON). The DON stated that if either one of the parameters were met, then the Norvasc should be given. After reviewing the MAR, she agreed that the Norvasc should have been given on the five occasions in November listed above.

Fundamentals of Nursing, 6th Edition, Potter-Perry, page 419, provides the following guidance regarding physicians' orders, " The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients. Therefore all orders must be assessed, and if one is found to be erroneous or harmful, further clarification from the physician is necessary."

The issue was reviewed with the Administrator and DON at the end of day meeting on 12/1/16. No further information was provided.

F 323 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT

F 323

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| F 323 SS=D | Continued From page 25<br>HAZARDS/SUPERVISION/DEVICES | F 323 | | |

(d) Accidents.
The facility must ensure that -

(1) The resident environment remains as free from accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

(1) Assess the resident for risk of entrapment from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, the facility staff failed for two residents, (Resident #4 and Resident #15) in a survey sample of 20 residents, to provide a safe living environment.

1. Resident #4's safety alarm was non functional during several falls and on observation.

2. Resident #15's safety alarm was non

**F323**
**Corrective Action(s):**
Resident #4's attending physician has been notified that facility staff failed to apply and maintain a physician ordered wheelchair alarm and self-releasing seat belt alarm per physician order. A facility incident and accident form has been completed for this incident.

Resident #15's attending physician has been notified that facility staff failed to apply and maintain a physician ordered bed and wheelchair alarm per physician order. A facility incident and accident form has been completed for this incident.

**Identification of Deficient Practices/Corrective Action(s):**
All other residents with physician ordered bed and wheelchair alarms or other preventive devices to prevent falls may have been potentially affected. The DON and/or ADON will conduct a 100% review of all residents with physician ordered alarms and fall prevention devices to identify residents at risk for inconsistent application and monitoring of the equipment. All residents identified at risk will be corrected at time of discovery and an Incident & Accident form will be completed for each negative finding. The attending physician will be notified of each incident.

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functional during observation.

The findings included:

1. Resident #4's safety alarm was non functional during several falls and on observation.

Resident #4 was admitted to the facility on 12/12/14. Diagnoses for Resident #4 included but not limited to Hypertension, depression, dementia and psychiatric symptoms Resident #4's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 9/7/16 coded Resident #4 with a BIMS (brief interview of mental status) score of "0" out of a possible 15, or severe cognitive impairment. In addition, the Minimum Data Set coded Resident #4 as not walking in the last seven days, and used a wheelchair with limited assistance with one staff member. The resident was coded as sustaining one fall since the last review, with no injury.

On 11/30/16 at 9:25 AM, Resident #4 was observed up in the wheelchair on the "A" side unit (Resident #4 lives on "B" side). The resident had a self releasing seat belt for safety, with an attached alarm. The alarm was checked and it was not functional, it did not alarm when released.

On 11/30/16 at 9:30 AM, the restorative CNA (certified nursing assistant) D released the self releasing seat belt. It did not alarm, did not alarm when resident was standing. CNA (D) checked the plug, "not fully plugged in." The alarm was now functional.

On 12/1/16 at 11:00 AM, the alarm was checked and was in working order.

**Systemic Change(s):**
The facility policy and procedure for fall prevention and management has been reviewed and no revisions are warranted at this time. The DON and/or regional nurse consultant will inservice all nursing staff regarding proper use of fall prevention equipments to include wheelchair and bed alarms to prevent falls.

**Monitoring:**
The DON is responsible for maintaining compliance. The DON, ADON and/or designee will perform daily inspections of all residents with physician order fall prevention devices to monitor for compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these reviews will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.
**Completion Date: 1/16/17**

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On 11/30/16, the clinical record was reviewed and revealed a physician's order dated 9/8/16 for a "pressure alarm to wheelchair" and a "self releasing seat belt alarm to the wheelchair."

Further review of the clinical record revealed the resident sustained six falls during which the fall alarm was not functional and had to be replaced. They are as followed:

4/18/16: fall, bed alarm did not sound, replaced the alarm.
5/13/16: fall, pressure alarm did not sound.
6/25/16: fall, alarm on, not sounding (wheelchair).
9/1/16: fall, alarm on, not sounding, new pressure alarm to bed.
9/17/16: fall, alarm on, not sounding, replaced alarm.
11/11/16: fall, alarm on, not sounding (bed alarm), new seat belt alarm
11/18/16: fall (wheelchair), alarm replaced.

The above falls resulted in no injury to the resident.

Review of the care plan dated 9/13/16 which revealed: "At risk for falls ...decreased safety awareness." Interventions included "Pressure alarm to wheelchair, pressure alarm to bed, safety belt to wheelchair monitored and adjusted as needed, self releasing seat belt to wheelchair."

On 12/1/16 at 2:10 PM, the DON (director of nursing) was questioned about the fall alarms. She stated, "CNA's check them and sign them off each shift (check list provided). If they are not sounding, we check and replace the alarms." An

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inventory was provided where the facility had ordered new alarms: Five pad alarms in February, five in June, 10 in July, three in September, 10 pad alarms and five pull string magnet alarms in October, and four self releasing belts in November.

On 12/1/16 at 6:45 PM, the Administrator and DON were notified of above findings.

2. Resident #15's safety alarm was non functional during observation.

Resident # 15 was admitted to the facility on 2/13/04. Diagnoses for Resident #15 included but not limited to Hypertension,dementia and intracranial hemorrhage. Resident #15's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 9/28/16 coded Resident #15 with a BIMS (brief interview of mental status) score of "8" out of a possible 15, or moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #15 as not walking in the last seven days, and used a wheelchair with standby assistance with one staff member. The resident was coded as sustaining one fall since the last review, with no injury.

On 11/30/16 at 10:00 AM, Resident #15 was observed in the hallway in his wheelchair. A fall alarm was attached to the wheelchair; the alarm did not sound when activated.

On 12/1/16 at 10:15 AM, Resident #15 was observed in the hallway. Restorative CNA (certified nursing assistant) E stood resident up from the pressure alarm on his chair; it did not sound. CNA (E) stated, "It should sound right

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| F 323 | Continued From page 29<br>away."<br><br>Review of the clinical record revealed a physician's order dated 11/21/16 for a "pressure alarm to bed and wheelchair.<br><br>Review of the care plan dated 9/28/16 revealed the resident was at risk for falls due to right foot drop and an intervention for a "pressure alarm to bed and wheelchair."<br><br>On 12/1/16 at 6:45 PM, the Administrator and DON were notified of above findings. | F 323 | | |
| F 333 SS=E | 483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and clinical record review the facility staff failed for 1 resident (Resident #18) to ensure the resident was free from a significant medication error.<br><br>1. Resident #18 received 72 additional doses of Vancomycin (antibiotic) after the the resident was already treated for C. diff (Clostridium difficile- a gastrointestinal infection).<br><br>The findings included:<br><br>Resident #18 received 72 additional doses of Vancomycin (antibiotic) after the the resident was already treated for C. diff (Clostridium difficile- a gastrointestinal infection frequently caused by antibiotic usage). | F 333 | **F333**<br>**Corrective Action(s):**<br>Resident #18's attending physician has been notified that the facility failed to administer Vancomycin per physician order. The nurse involved in the medication error is no longer employed at the facility. A facility Incident & Accident form was completed for each incident.<br><br>**Identification of Deficient Practice(s) and Corrective Action(s):**<br>All other residents receiving Physician ordered antibiotics may have potentially been affected. A 100% review of all residents with antibiotic orders will be conducted to identify residents at risk. All residents identified at risk will be corrected at time of discovery and appropriate disciplinary action taken. An Incident and Accident form will be completed for each negative finding. | |

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| F 333 | Continued From page 30<br>Resident # 18 was admitted to the facility on 10/28/16. Diagnoses for Resident #18 included but not limited to Hypertension, End Stage Renal Disease, lupus and bipolar disorder. Resident #18's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 11/1416 coded Resident #18 with a BIMS (brief interview of mental status) score of "11" out of a possible 15, or minimal cognitive impairment.<br><br>There were no observations of this resident as this was a closed record review.<br><br>Review of the clinical record revealed the resident was was placed on contact isolation for C. Diff on admission of 10/28/16. Further review of the clinical record revealed the resident had no episodes of diarrhea during her stay. A nurse's note dated 11/17/16 contained the note: "Contact isolation maintained." A nurse's note dated 11/8/16 read: "Pt (patient) roaming halls in wheelchair and advised on importance in staying in compliance with contact isolation precautions. Resident refused."<br><br>Review of the hospital discharge record dated 10/28/16 revealed the following: "C. diff colitis: resolved. Continue Vancomycin 125 mg (milligrams) every 6 hours for one more day." Review of the discharge medications included the following: "Vancomycin 125 mg 1 cap (capsule) every six hours 1 day, no refills." Information for the Referring Provider read as followed: "Admitted on 10/13/16 for diarrhea with positive C diff colitis. She was treated with Vancomycin with significant improvement. She will be sent to SNF (skilled nursing facility) with one more day of Vancomycin 125 mg every six hours. Stop date 10/29/16." | F 333 | **Systemic Change(s):**<br>The facility policy and procedure has been reviewed and no changes are warranted at this time. All Licensed staff will be inserviced on the facility policy and procedure by the DON regarding the administration of medications per physician orders to include the proper administration of antibiotics as ordered by the physician.<br><br>**Monitoring:**<br>The Director of Nursing is responsible for maintaining compliance. The DON and/or designee will do weekly MAR audits to monitor for compliance. Any negative findings will be addressed at the time of discovery and appropriate disciplinary action taken. Detailed findings of these results will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.<br>**Completion Date: 1/16/2017** | |



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Resident #18 received Vancomycin 125 mg every six hours while in the hospital. The discharge summary included information that the course of treatment would be completed on 10/29/16 (at the SNF facility) with one more day of the antibiotic. The discharge summary included that the " C. diff was resolved. "
Resident #19 ' s transcribed orders dated 10/28/16, which were signed by the physician on this date, included the order for Vancomycin 125 mg every six hours by mouth. There was no notation in the order to stop the Vancomycin on 10/29/16. The resident continued to receive the Vancomycin until her discharge date of 11/17/16. There was no stop date for the antibiotic even though the resident had no episodes of diarrhea during the facility stay.
Review of the MAR (medication administration record) revealed the resident received 72 additional doses of Vancomycin during the skilled stay.

On 12/1/16 at 2:50 PM, the DON (director of nursing) was questioned about the facility's C. diff policy. The DON stated, "The resident is placed on contact isolation for C. diff. Once antibiotic therapy is completed, and if still symptomatic, we do a stool culture." She went on to state that while on antibiotics, keep on with the isolation precautions. In addition she said that the physician would usually want a stool culture once the treatment with antibiotics was completed. She stated, "The CDC (centers for disease control) lean away from treating with antibiotics and if non symptomatic, take off isolation."

In Clinical Practice Guidelines for Clostridium Difficile Infection in Adults listed treating C. diff with "Vancomycin (Vancomycin is the drug of

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| F 333 | Continued From page 32<br>choice) 125 mg four times daily for 10-14 days."<br><br>Review of the facility policy on Clostridium Difficile 10 (E) read as followed: "residents who are asymptomatic (diarrhea free) for 48 hours can be removed from precautions."<br><br>On 12/1/16 at 6:45 PM, the Administrator and DON were notified of above findings. | F 333 | | |
| F 441 SS=D | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; | F 441 | **F441**<br>**Corrective Action(s):**<br>The attending physician for resident #16 was notified that the facility failed to ensure contact precautions were implemented when caring for resident #16. LPN-A and CNA-C have been inserviced by the DON on the proper contact isolation procedure to be utilized when assessing and assisting residents on isolation precautions. An Incident & Accident form was completed for each incident.<br><br>The attending physician for resident #18 was notified that the facility placed the resident on contact isolation for a resolved infection. An Incident & Accident form was completed for each incident. | |

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| F 441 | Continued From page 33<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by: | F 441 | **Identification of Deficient Practice(s) & Corrective Action(s):**<br>All residents on isolation may have the potential to be affected by improper use of PPE, hand washing and improper infection control techniques. The DON,ADON and/or Unit Manager will conduct audits on residents on isolation to observe proper infection control practices, proper PPE use and hand washing during resident care. Any negative findings will be addressed immediately and disciplinary action taken as needed. A facility Incident and Accident form will be completed for each negative finding.<br><br>**Systemic Change(s):**<br>The facility policy and procedures have been reviewed and no changes are warranted at this time. All nursing staff will be inserviced on the facility policy and procedure on infection control to include the proper use of PPE for residents on isolation by the DON, ADON and/or Regional Nurse consultant.<br><br>**Monitoring:**<br>The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Manager will perform random weekly audits of residents on isolation precautions to monitor nursing staff for compliance. Any negative findings will addressed at time of discovery and disciplinary action taken as warranted. Findings of the audits will be reported to the QA Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.<br>**Completion Date:** 1/16/17 | |

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Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to ensure an effective infection control program for 2 residents (Resident #16 and #18) of 20 residents in the survey sample.

1. For Resident #16 the facility staff failed to ensure contact isolation precautions were followed for a resident with MRSA.

2. Resident #18 was placed on contact isolation for a resolved C difficile (Clostridium difficile) infection.

The findings included:

Resident #16, a 58 year old, was admitted to the facility on 11/29/16. His diagnoses included gangrene, Methicillin Resistant Staphylococcus aureus (MRSA) infection, peripheral vascular disease and end stage renal disease.

Resident #16 was new to the facility and did not have a Minimum Data Set assessment.

Resident #16's physician orders were reviewed. Included was an order dated 11/30/16 that read "contact isolation for MRSA: wounds." The 'Nursing Admitting Assessment" date 11/29/16 documented that Resident #16 had wounds to the fingers, toes and the right shin.

On 11/30/16 at 3:30 p.m., Resident #16's room was observed to have a red sign on the door that read "Isolation". A plastic drawer was observed outside of the room containing personal

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protective equipment (PPE). The drawer was not opened.

Licensed Practical Nurse A (LPN A) was observed approximately two feet into the room. LPN A was wearing a mask and gloves, no gown. There was also a male visitor in the room without gloves or gown.

On 12/1/16 at 1:09 p.m., contact precaution procedures were discussed with LPN A. When asked what was supposed to happen in order to enter a contact precaution room, LPN A stated that a gown and gloves needed to be worn and a mask was optional. When asked who needed to follow this procedure, LPN A stated everyone needed to follow. When asked why she was in the room without a gown, LPN A stated that she was unsure what specific precautions needed to be followed so she had one of the therapy staff who was standing outside of the room check for her. She stated that the therapy staff told her that she only needed to wear a gown if she (LPN A) was going to touch resident.

LPN A was asked if there were gowns available in the drawer when she was preparing to enter the room. LPN A stated no.

On 12/1/16 at 8:50 a.m., LPN B, Unit Manager, was asked about the procedure for contact precautions. She stated that gown and gloves were required and should be put on before crossing the threshold into the room. She stated a mask was optional. She stated that gown and gloves were required for everyone that entered the room.

On 12/1/16 at 8:52 a.m., Certified Nursing

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Assistant C (CNA C) entered Resident #16's room. CNA C wore a gown and a mask. She did not wear gloves. She walked through the room and touched the resident's closet. She walked back to the door and removed the gown and mask, disposing them appropriately. She picked up the resident's breakfast tray in the room and exited the room to place the tray on the cart. She re-entered the room without gown and gloves and washed her hands.

At 8:58 a.m., CNA C was asked about the contact isolation procedure. CNA C stated that a gown needed to be worn and a mask was optional. She did not mention the need for gloves. She stated that she took the mask and gown off so she could exit the room to bring the tray out and then returned to the room because she needed to wash her hands.

On 12/1/16 at 2:50 p.m., contact isolation precautions were reviewed with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON). They stated that PPE, to include mask, gloves and gown, were required to enter the room. They stated that the PPE should be removed and hands needed to be washed before exiting the room.

The facility policy titled "Isolation- Categories of Transmission- Based Precautions" was reviewed. Under the section titled "Contact Precautions" read "4. Gloves and Handwashing, In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, non-sterile) when entering the room." In addition, the policy read "remove gloves before leaving the room and perform hand hygiene."

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| F 441 | Continued From page 37<br>The policy also read "5. Gown, Wear a disposable gown upon entering the Contact Precautions room or cubicle."<br><br>The Administrator and DON were notified of the contact precaution issue at the end of day meeting on 12/1/16. | F 441 | | |

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2. Resident #18 was placed on contact isolation for a resolved C difficile (Clostridium difficile) infection.

Resident # 18 was admitted to the facility on 10/28/16. Diagnoses for Resident #18 included but not limited to Hypertension, End Stage Renal Disease, lupus and bipolar disorder. Resident #18's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 11/14/16 coded Resident #18 with a BIMS (brief interview of mental status) score of "11" out of a possible 15, or minimal cognitive impairment.

There were no observations of this resident as this was a closed record review.

Review of the clinical record revealed the resident was was placed on contact isolation for C Difficle on admission of 10/28/16. Further review of the clinical record revealed the resident had no episodes of diarrhea during her stay. A nurse's note dated 11/17/16 contained the note: "Contact isolation maintained." A nurse's note dated 11/18/16 read: "Pt (patient) roaming halls in wheelchair and advised on importance in staying in compliance with contact isolation precautions. Resident refused."

Review of the hospital discharge record dated 10/28/16 revealed the following: "C. diff colitis: resolved. Continue Vancomycin 125 mg (milligrams) every 6 hours for one more day." Review of the discharge medications included the

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following: "Vancomycin 125 mg 1 cap (capsule) every six hours 1 day, no refills." Information for the Referring Provided read as followed: "Admitted on 10/13/16 for diarrhea with positive C diff colitis. She was treated with Vancomycin with significant improvement. She will be sent to SNF (skilled nursing facility) with one more day of Vancomycin 125 mg every six hours. Stop date 10/29/16."

Review of the MAR (medication administration record) revealed the resident received 72 doses of Vancomycin during the skilled stay.

On 12/1/16 at 2:50 PM, the DON (director of nursing) was questioned about the facility's C. diff policy. The DON stated, "Contact isolation for C. diff. Once antibiotic therapy is completed, and if still symptomatic, do a stool culture." She went on to state that while on antibiotics, keep on with the isolation precautions. In addition she said that the physician would usually want a stool culture once the treatment with antibiotics were completed. She stated, "The CDC (centers for disease control) lean away from treating with antibiotics and if non symptomatic, take off isolation."

In Clinical Practice Guidelines for Clostridium Difficile Infection in Adults listed treating C. diff with "Vancomycin (Vancomycin is the drug of choice) 125 mg four times daily for 10-14 days."

Review of the facility policy on Clostridium Difficile 10 (E) read as followed: "residents who are symptomatic (diarrhea free) for 48 hours can be removed from precautions."

On 12/1/16 at 6:45 PM, the Administrator and



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DON were notified of above findings.

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 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 physician ordered lab work for one Resident (Resident #11) in a survey sample of 20 Residents.

For Resident #11, the facility staff failed to obtain a BMP (basic metabolic panel) per physician's order.

The findings included:

Resident #11, a female, was admitted to the facility 1/2/15. Her diagnoses included hypertension, unspecified dementia with behavior disturbances, osteoporosis, depression, peripheral vascular disease, gastroesophageal reflux disease, and hypothyroidism.

Resident #11's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/29/16 was coded as a quarterly 90 day assessment. She was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was also coded as requiring total to extensive assistance of one staff member to perform her activities of daily living.

F 441

F 502

**F502**
**Corrective Action(s):**
Resident #11's attending physician has been notified that the facility failed to obtain a BMP lab test as ordered by the physician. A Facility Incident & Accident form has been completed for the missing labs.

**Identification of Deficient Practice(s) & Corrective Action(s):**
All other residents who had physician ordered lab tests may have potentially been affected. A 100% audit of all resident's lab orders will be completed to identify residents at risk. All negative findings will be corrected at the time of discovery. The attending physicians will be notified of the missing labs, labs not obtained timely and labs obtained without a physician order. A facility Incident & Accident Form will be completed.

**Systemic Changes:**
The facility policy and procedure has been reviewed and no changes are warranted at this time. The laboratory tracking system has been reviewed and implemented to track and validate that required lab work has been completed per physician order and policy and procedure. The DON and/or Nurse Consultant will inservice all licensed staff on physician ordered laboratory-testing, protocols, & tracking system used.

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| F 502 | Continued From page 41<br><br>Review of Resident #11's clinical record revealed she was hospitalized and returned to the facility 6/28/16. Included with her re-admission orders was for the following lab work to be obtained, "TSH (thyroid stimulating hormone) and BMP (basic metabolic panel) on 6/29/16."<br><br>Included within her clinical record were lab work results that included a TSH however no results were evident for a BMP.<br><br>When interviewed, ADM (the ADON -assistant director of nursing), said 12/1/16 at 3:10 p.m., the staff obtained a CMP (comprehensive metabolic panel) instead of the physician ordered BMP.<br><br>The administrator, DON (director of nursing), and ADON were informed of the failure of the staff to obtain a BMP per physician's order for Resident #11, 12/1/16 at end of day meeting. | F 502 | **Monitoring:**<br>The DON is responsible for maintaining compliance. The DON and/or designee will complete the Facility Lab audit tool weekly to monitor for compliance. Any negative findings will be reported to the attending physician and disciplinary action will be taken as warranted. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice.<br>**Completion Date: 1/16/17** | |
| F 504 SS=D | 483.50(a)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN<br><br>(a) Laboratory Services<br><br>(2) The facility must-<br><br>(i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility failed to obtain a physician's order prior to obtaining blood work for one | F 504 | **F504**<br>**Corrective Action(s):**<br>Resident #11's attending physician has been notified that the facility obtained a CBC and a CMP laboratory test without a physician order. A facility Incident & Accident form has been completed for this incident | |

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| F 504 | Continued From page 42<br>Resident (Resident #11) in a survey sample of 20 Residents.<br><br>For Resident #11 a CMP (comprehensive metabolic panel) and CBC (complete blood count) were obtained without a physician's order.<br><br>The findings included:<br><br>Resident #11, a female, was admitted to the facility 1/2/15. Her diagnoses included hypertension, unspecified dementia with behavior disturbances, osteoporosis, depression, peripheral vascular disease, gastroesophageal reflux disease, and hypothyroidism.<br><br>Resident #11's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/29/16 was coded as a quarterly 90 day assessment. She was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was also coded as requiring total to extensive assistance of one staff member to perform her activities of daily living.<br><br>Review of Resident #11's clinical record revealed a CBC and CMP were obtained 6/30/16. A thorough review of the clinical record revealed no physician's order for the blood work to be obtained.<br><br>When interviewed ADM C stated 12/1/16 at 3:10 p.m., the blood work was obtained as part of routine labs after hospitalization. She stated the CBC and CMP were obtained as part of her other blood work and after reviewing the clinical record, there was no physician's order. | F 504 | **Identification of Deficient Practice(s) & Corrective Action(s):**<br>All other residents may have potentially been affected. A 100% audit of resident clinical records will be completed to identify residents who may have had laboratory tests completed without a physician order. All negative findings will be corrected at the time of discovery and the attending physician will be notified. A Facility Incident & Accident form will be completed for each incident.<br><br>**Systemic Changes:**<br>The facility policy and procedure has been reviewed and no changes are warranted at this time. Licensed staff will be inserviced by the DON and/or nurse consultant on the policy and procedure for obtaining resident laboratory tests, which includes obtaining a physician order prior to obtaining the lab test.<br><br>**Monitoring:**<br>The DON is responsible for maintaining compliance. The DON ,ADON and/or Unit manager will review all lab tests results weekly to ensure that all resident lab tests obtained had an appropriate physician order for the lab tests prior to obtaining. Any negative findings will be reported to the attending physician and the appropriate disciplinary action taken for staff involved. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice.<br>**Completion Date: 1/16/17** | |



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| F 504 | Continued From page 43<br>The administrator, DON (director of nursing) and ADM C were informed of the failure of the staff to obtain a physician's order prior to obtaining a CBC (complete blood count) and CMP for Resident #11, 12/1/16 at end of day meeting. | F 504 | | |
| F 514 SS=D | 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>(i) Medical records.<br>(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br><br>(i) Complete;<br><br>(ii) Accurately documented;<br><br>(iii) Readily accessible; and<br><br>(iv) Systematically organized<br><br>(5) The medical record must contain-<br><br>(i) Sufficient information to identify the resident;<br><br>(ii) A record of the resident's assessments;<br><br>(iii) The comprehensive plan of care and services provided;<br><br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br><br>(v) Physician's, nurse's, and other licensed professional's progress notes; and | F 514 | **F514**<br>**Corrective Action(s):**<br>Resident #2's attending physician has been notified that the facility staff failed to ensure that physician ordered TSH laboratory results were in the clinical record. A facility incident and accident form has been completed for this incident.<br><br>Resident #3's attending physician has been notified that the facility staff failed to ensure a physician progress note was in the clinical record. A facility incident and accident form has been completed for this incident.<br><br>Resident #13's attending physician has been notified that the facility staff failed to ensure physician orders were legible in the clinical record. A facility incident and accident form has been completed for this incident. | |

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(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for three Residents (Residents' #2, #3 and #13) in a survey sample of 20 Residents.

1. For Resident #2, the facility staff failed to ensure TSH (thyroid stimulating hormone) blood results were in the clinical record;

2. For Resident #3, the facility staff failed to ensure a physician's progress note was in the clinical record; and

3. For Resident #13, the facility staff failed to ensure physician orders were legible.

The findings included:

1. For Resident #2, the facility staff failed to ensure TSH (thyroid stimulating hormone) blood results were in the clinical record.

Resident #2, a female, was initially admitted to the facility 10/23/15. Her diagnoses included chronic congestive heart failure, arteriosclerotic cardiovascular disease, type II diabetes mellitus, hypertension, chronic kidney disease, osteoarthritis, and pruritis.

Resident #2's most recent MDS with an ARD (assessment reference date) of 10/25/16 was coded as a quarterly assessment. Resident #2 was coded as having minimal memory deficits

**Identification of Deficient Practices & Corrective Action(s):**
All other residents may have potentially been affected. A 100% audit of all resident medical records will be conducted by the DON, ADON and/or Medical Records clerk to identify residents at risk for an inaccurate medical record and illegible documentation. All negative findings will be clarified and/or corrected at time of discovery and the attending physician notified of the incident. A facility Incident & Accident form will be completed for each negative finding.

**Systemic Change(s):**
The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff and Medical Records clerk will be inserviced by the DON or regional nurse consultant on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include accurate documentation of medical information in the appropriate medical record and maintaining legible physician orders according to the acceptable professional standards and practices.

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and required minimal assistance with making daily life decisions. Resident #2 was coded as needing extensive to total assistance of one staff member to perform all of her activities of daily living with the exception of transferring and eating. For transferring she was coded as needing limited assistance of one staff and for eating she was coded as requiring supervision.

Review of Resident #2's clinical record revealed a signed physician's order that included:

"Lab: TSH on 11/7/16."

A thorough review of Resident #2's clinical record revealed no lab work results for a TSH that was obtained on 11/7/16.

When interviewed, EMP. A, the medical records clerk, stated he would find the results, 11/30/16 at 10:58 a.m. A copy of the blood work was presented 11/30/16 at 1:30 p.m. At 5:10 p.m. ADM C stated the original copy was unable to be located and the lab faxed another copy to the facility. ADM C stated the facility had received the results and showed the lab log where the results were documented as having returned. A notation was evident on the log that indicated the physician had been notified of the results and no new orders were necessary.

The administrator, DON (director of nursing) and ADON (assistant director of nursing) were informed of the failure of the staff to ensure TSH results present in Resident #2's clinical record 12/2/16 at end of day meeting.

2. For Resident #3, the facility staff failed to ensure a physician's progress note was in the

**Monitoring:**
The DON is responsible for maintaining compliance. The DON, and/or ADON will audit medical records, MAR's, TAR's, ADL records and care plans weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice.
**Completion Date: 1/16/17**

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clinical record.

Resident #3, a male, was admitted to the facility 10/19/16. His diagnoses included chronic obstructive pulmonary disease, hypertension, transient ischemic attack, and hyperlipidemia.

Resident #3's most recent MDS with an ARD of 10/21/16 was coded as an annual assessment. He was coded as having some short and long term memory deficits and required assistance with making daily life decisions. He was also coded as requiring supervision of one staff member to perform all of his activities of daily living.

Review of Resident #3's clinical record revealed no physician's progress note was evident for the time frame between 4/21/16 and 7/5/16. When asked, EMP. A stated he would review the record to check on the progress note, 11/30/16 at 1:36 p.m. At 4:50 p.m. on 11/30/16, EMP. A presented a faxed copy of a physician's progress note dated 5/24/16. When interviewed, EMP A stated the note had been faxed from the physician's office. EMP. A stated the physician sometimes forgets to leave the note at the facility after he assesses the Resident and completes the progress note.

The administrator, DON, and ADON were informed of the failure of the staff to ensure a progress note completed 5/24/16 was filed within Resident #3's clinical record, 12/1/16 at end of day meeting.

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3. For Resident #13, the facility staff failed to ensure physician orders were legible.

Resident #13, a female, was admitted to the

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facility 5/1/13 and readmitted after a hospitalization 4/10/16. Her diagnoses included osteoporosis, history of breast cancer, elevated cholesterol, deep vein thrombosis, nonrheumatic aortic valve disorder, hypertension, type II diabetes mellitus, contact dermatitis, muscle weakness, cardiac arrhythmia, and contractures.

Resident #13's most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/15/16 was coded as a quarterly assessment. Resident #13 was coded as having some short and long term memory deficits and required moderate assistance with making every day life decisions. Resident #13 was coded as requiring extensive to total assistance with performing her activities of daily living.

Review of Resident #13's clinical record revealed three physician's telephone orders that were unable to be read. The orders were on NCR paper and the original (or first page of the NCR paper) were so light that they either were very difficult to decipher or were too light to be read at all.

EMP. A, the medical records staff, stated 11/30/16 at 2:35 p.m., the orders are written on the NCR paper and the top order is removed. EMP. A said the orders are given to the physician in batches and the signed orders are then put back on the record. EMP. A stated he thought he had the signed orders and would look for the orders in question. The orders in question were from October, 2016. He also stated the staff needed to press down hard when entering the orders.

The administrator, DON, and ADON were

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| F 514 | Continued From page 48<br>informed of the failure of the staff to ensure physician orders were legible for Resident #13, 12/1/16 at end of day meeting. | F 514 | | |