STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING ______ B. WING ______	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	**5872 HANKS STREET PO BOX 1087 DUBLIN, VA 24084**

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 07/25/17 through 07/27/17. Two complanits were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 132 certified bed facility was 125 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents 1 through 21) and 4 closed record reviews (Residents 22 through 25).	F 000		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F 278		9/8/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/18/2017

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

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F 278	Continued From page 1 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) assessment for 1 of 25 Residents in the sample survey, Resident #13. For Resident #13 the facility staff failed to ensure accurately code a Significant Weight loss over the past 6 months on a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 6/22/17. The Findings Included: Resident #13 was a 66 year old male who was originally admitted on 1/19/17 and readmitted on 3/29/17. Admitting diagnoses included, but were not limited to: dementia with behaviors, adult failure to thrive, hypertension, cerebral infarct, seizures, alerted mental status, chronic kidney disease, major depression and obstructive uropathy and Alzheimer's. The most current Minimum Date Set (MDS)	F 278	In investigation it appears this reported deficiency is related to resident #6 rather than resident #13. Resident #6 Correction: On 7/26/17, Resident #6's MDS with ARD of 6/22/17 was modified in section K0300 to reflect a significant weight loss. MDS was transmitted and accepted. Resident #6 was reviewed and did not meet criteria for a significant change assessment. Potential Residents: The most recent MDS of all current residents will be reviewed for accuracy of coding in section K0300. Any discrepancies will be immediately	

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located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 6/22/17. The facility staff coded that Resident #13had short and long term memory loss and required extensive assistance with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #13 required limited (2/2) to total nursing care (4/2) with ADL's. In Section K. Swallowing and Nutritional Status the facility staff documented that Resident #13's weight was 117 pounds. In Section K0300. Weight Loss the facility staff documented that Resident #13 did have a weight loss.

On July 26, 2017 at 8 a.m. the surveyor reviewed Resident #13's clinical record. Review of the clinical record produced Resident #13's weights. Resident #13's weights were documented as:

1/24/17	131.3 pounds
1/31/17	135.4 pounds
2/7/17	133.8 pounds
2/21/17	134 pounds
3/7/17	127.4 pounds
3/30/17	115.7 pounds
4/4/17	120.3 pounds
4/11/17	122.9 pounds
4/19/17	124.1 pounds
5/2/17	121.2 pounds
5/16/17	118.9 pounds
5/31/17	122.3 pounds
6/8/17	119.2 pounds
6/14/17	117.8 pounds

The surveyor was able to determine that Resident #13 had lost 13.5 pounds (11.3%) from 1/24/17 through 6/14/17.

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investigated and MDS modified as indicated.

Systematic Changes:

The MDS Coordinator will educate the Dietary Manager on proper procedure for coding section K0300 of the MDS.

Monitoring:

The QA Coordinator or designee will select 10% of current residents with a MDS completed during the previous month and conduct a QA audit monthly using the MDS Significant Weight Change audit tool to identify any MDS coding discrepancies for section K0300. The DON and administrator will receive reports of monthly audit. Any staff identified as not accurately coding section K0300 of the MDS will be re-educated and/or counseled as necessary. After the 3-month period, QAA Committee will re-evaluate the frequency of the audit.

DON and Administrator will review an aggregate analysis of the QA audit reports and report monthly findings to the QAA Committee.

QAA Committee will monitor reports monthly for patterns and trends and recommend adjustments accordingly.

Recommendations will be reviewed quarterly by the Medical Director, QAA Committee, DON and Administrator.

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F 278	Continued From page 3 On July 26, 2017 at 9:30 a.m. the surveyor notified the MDS Nurse, who was a Registered Nurse (RN), that Resident #13's Quarterly MDS with the ARD of 6/22/217 was inaccurate. The surveyor reviewed Resident #13's clinical record with the MDS Nurse. The surveyor reviewed Resident #13's weights with the MDS Nurse. The surveyor pointed out that Resident #13 had a significant weight loss within the past 6 months. The surveyor informed the MDS Nurse that the weight loss was about 13.5 pounds. The surveyor then reviewed the Quarterly MDS with the ARD of 6/22/17 with the MDS Nurse. The surveyor pointed out that the MDS did not capture the Significant Weight loss over the past 6 months. The MDS Nurse stated that the Dietary Manager did Section K of the MDS. On July 26, 2017 at 3:10 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Quality Assurance Nurse (QAN) and the Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #13's Quarterly MDS with the ARD of 6/22/17 was inaccurate. The surveyor notified the AT that Resident #13 had a Significant Weight loss over the past 6 months. The surveyor notified the AT that the Quarterly MDS did not code/capture the Significant Weight loss. No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #13.	F 278		
F 285 SS=D	PASRR REQUIREMENTS FOR MI & MR CFR(s): 483.20(e)(k)(1)-(4) (e) Coordination.	F 285		9/8/17

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A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:

(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident’s assessment, care planning, and transitions of care.

(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.

(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.

(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:

(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of

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services, whether the individual requires specialized services; or

(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

(2) Exceptions. For purposes of this section-

(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-

(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and

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(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

(3) Definition. For purposes of this section-

(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).

(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.

(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to obtain a level 1 PASRR (pre-admission screening and Resident review for 1 of 25 Residents, Resident #8.

The findings included:

For Resident #8 the facility staff failed to obtain a level 1 PASRR within 30 days of admission.

Resident #8 was admitted to the facility on 10/25/14 and readmitted on 12/25/15. Diagnoses included but not limited to anemia, hypertension,

Resident #8

Correction:

On 7/27/17, Social Service Director completed a level 1 PASRR on Resident #8.

Potential Residents:

The medical records of all current residents will be reviewed for the presence of a completed level 1 PASRR.

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F 285	Continued From page 7 gastroesophageal reflux disease, end stage renal disease, hyperlipidemia, arthritis, Alzheimer's disease, cerebrovascular accident, and dementia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 05/07/17 coded the Resident as 14 out of 15 in section C, cognitive patterns. This is an annual MDS. Resident #8's clinical record was reviewed on 07/26/17. The surveyor could not locate a PASRR. Surveyor spoke with social services director on 7/26/17 at approximately 1350 regarding the missing PASRR. Social services director stated that Resident #8 had originally been admitted to the facility as a skilled Resident, and had no plans to stay long-term; therefore the hospital had not completed the PASRR. The concern of the missing PASRR was discussed with the administrative staff during a meeting on 07/26/17 at approximately 1510. On 07/27/17 at approximately 0755, social services director provided surveyor with a copy of a completed PASRR for Resident #8. No further information was provided prior to exit.	F 285	Any resident identified without a required level 1 PASRR will be reviewed and a PASRR will be completed. Systematic Changes: The QAA Committee will review and revise as necessary the policy and procedure for Level 1 PASRR. All level 1 PASRRs will be uploaded to the resident's electronic medical record upon admission. Social Service Director or designee will review the medical records of all new admissions for the presence of a level 1 PASRR. Any resident admitted without a level 1 PASRR will have one completed as part of the admission process. Monitoring: The QA Coordinator or designee will select 10% of current residents admitted to the facility during the previous month and conduct a QA audit monthly using the Level 1 PASRR audit tool to identify any resident without a level 1 PASRR. The DON and administrator will receive reports of monthly audit. Any staff identified as not completing a required level 1 PASRR will be re-educated and/or counseled as necessary. After the 3-month period, QAA Committee will re-evaluate the frequency of the audit. DON and Administrator will review an aggregate analysis of the QA Audit	

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F 285	Continued From page 8	F 285	Reports and report monthly findings to the QAA Committee. QAA Committee will monitor reports monthly for patterns and trends and recommend adjustments accordingly. Recommendations will be reviewed quarterly by the Medical Director, QAA Committee, DON and Administrator.	
F 309 SS=E	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 309		9/8/17

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F 309	Continued From page 9 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review it was determined the facility staff failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 2 of 25 residents (Residents #16 & 13). ~ Resident #16- failed to communicate with dialysis facility per contractual agreement. ~ Resident #13 - failed to assess bowel movements and provide treatment for same. Findings: 1. The facility staff failed to maintain a contractual communication agreement with Resident #16's dialysis facility. Resident #16's clinical record review was conducted on 7/27/17 at 9:00 AM. Resident # 16 entered the facility on 4/28/17. Her diagnoses included end stage renal disease hypertension, peripheral vascular disease and anxiety. The latest MDS (minimum data set) assessment,	F 309	Resident #16 and Resident #13 Correction: Director of Nursing communicated with the dialysis center providing care for Resident #16 who has agreed to return treatment records following each dialysis treatment. Charge nurse will complete the Dialysis Communication form and send with Resident #16 to each dialysis treatment. Resident #13 will be assessed by the physician for bowel maintenance interventions. Potential Resident: The medical records of all current residents receiving dialysis care will be reviewed for communication between HRRC and the dialysis center. The medical records of all current residents will be reviewed to identify any	

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dated 7/25/17, coded the resident with mildly impaired cognitive function. Her communication skills were unimpaired. The resident required staff assistance for all the activities of daily living and oversite, only, to eat.

The latest CCP (comprehensive care plan) initiated on 5/1/17 documented the problem "The resident needs dialysis r/t End Stage Renal Disease - out to dialysis 3 times per week." The interventions included monitoring the dialysis site for infection, bleeding, thrill, & bruit. The CCP did not document any careplanning from the dialysis onsite center or any communications to or from same.

Resident #16's latest physician's orders, signed and dated on 6/19/17, included an order dialysis on Monday, Wednesday and Friday each week.

On 7/27/17 at 9:10, during the clinical record review, LPN I was asked about the facility's communications with the dialysis center, regarding the resident's vital signs, pre and post weights and any other pertinent data that was shared about the resident's assessments on dialysis days. LPN I said she didn't know anything about that. She noted if anything was transferred--it was probably in the Resident's duffel bag, in her room.

On 7/27/17 at 9:15 AM the resident was observed seated in her room and the surveyor asked about the duffel bag she carried to and from dialysis with her. The resident told the surveyor where the bag was, but stated, "I don't have anything but extra clothes in the bag. There's no dialysis book that I know of."

F 309 (Plan of Correction)

resident without a bowel movement in 3 days during the past 30 days without appropriate assessment and intervention. Any identified resident will be assessed and interventions made as indicated.

Systematic Changes:

The QAA Committee will review and revise as necessary the policy and procedure for Dialysis Care and the Dialysis Communication form.

Nurses will be inserviced on the policy and procedure for Dialysis Care and the Dialysis Communication form.

DON will contact dialysis centers to advise of the use and function of the Dialysis Communication form.

The Dialysis Communication form will be completed in part by nursing prior to dialysis and sent with the resident. The remainder of the form will be completed by the dialysis center and returned with the resident.

The completed Dialysis Communication form will be uploaded to the resident's electronic medical record.

The dialysis centers will fax resident treatment records to the Director of Nursing following each dialysis treatment. If records are not received, the DON will contact the dialysis center.

Dialysis treatment records will be

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The surveyor reviewed the contents of Resident #16's bag (with her permission) but did not find any documentation shared between the facility and the dialysis center.

On 7/27/17 at 9:15 AM RN I, who was Resident #16's unit manager, stated, "To my knowledge, they have not been sending them. I don't know if they send anything or not."

The DON was informed of the surveyor's findings at this point. The DON stated, "We have tried in the past to get them to send communication sheets. They won't return them."

The DON provided the surveyor with the facility contract with the dialysis center. The agreement, signed and dated December, 18, 2001, by representatives of both facilities, included the following under "Resident Information". Written protocol:
"The parties will mutually develop a written proposal governing the specific responsibilities, policies and procedures to be used in rendering dialysis services to residents at the ESRD (end-stage renal disease) Dialysis Unit, including......the development and implementation of a resident's care plan relative to the provision of dialysis services. The Nursing Center will provide for the interchange of information useful or necessary for the care of the resident and will inform the ESRD Dialysis Unit of a contact person at the nursing facility...."

The surveyor's findings were shared with the facility administrator prior to the survey team exit. No additional information was provided.
2. For Resident #13 the facility staff failed to monitor for bowel movements, assess the

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reviewed by the Unit Manager and uploaded to the resident's electronic medical record.

The QAA Committee will review and revise as necessary the policy and procedure for the Bowel Management Program.

Nurses will be inserviced on the policy and procedure for the Bowel Management Program.

Nurses will be inserviced on proper technique for performing and documenting an abdominal assessment.

Charge Nurses will review residents with no bowel movement in the past 3 days during each shift change report for appropriate intervention and follow-up.

The 3-11 supervisor or designee will review bowel movement documentation daily and identify any resident who has not had a bowel movement recorded in the past 3 days. Identified residents will be assessed and interventions made according to physician's orders and/or facility policy.

The Unit Manager or designee will daily through the workweek, review bowel movement documentation to identify for appropriate treatment and follow-up. Nurses identified as not following the Bowel Management policy and procedure and/or physician's orders will be re-educated and/or counseled as

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abdomen for bowel sounds and follow up on the administration of laxatives.

Resident #13 was a 91 year old female who was admitted on 1/20/17. Admitting diagnoses included, but were not limited to: dementia without behaviors, hallucinations, epilepsy, acute kidney failure, chronic kidney disease, repeated falls, and fracture of nasal bones, osteoarthritis, depression, anxiety, chronic pain and hypertension.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 7/13/17. The facility staff coded that Resident #13 had short and long term memory loss (1/1) and required extensive assistance (2) with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #13 required extensive (3/3) to total nursing care (4/2) with ADL's.

On July 26, 2017 at 1:15 p.m. the surveyor reviewed Resident #13's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "Docu Soft Capsule (Docusate Sodium) Give 100 mg by mouth one time at bedtime for constipation. GaviLAX Packet (Polyethylene Glycol 3350) Give 17 gram by mouth in the morning for constipation. Milk of Magnesia (MOM) Suspension 400 MG/5ML (Magnesium Hydroxide) Give 30 ML by mouth every 24 hours as needed for constipation. Bisacodyl (Dulcolax) Suppository Insert 1 suppository rectally one time a day for constipation." (sic)

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necessary.

Monitoring:

The QA Coordinator or designee will select 50% of current residents receiving dialysis treatment and conduct a QA audit weekly for 12 weeks using the Dialysis Communication audit tool to identify any resident without completed Dialysis Communication forms and/or treatment records from the dialysis center uploaded to the resident's electronic medical record. Any staff identified as not following the Dialysis Care policy and procedure will be re-educated and/or counseled as necessary. After the 3-month period, QAA Committee will re-evaluate the frequency of the audit. The QA Coordinator or designee will select 10% of current residents and conduct a QA audit weekly for 12 weeks using the Bowel Management audit tool to identify any resident without a bowel movement in 3 days and without appropriate assessment and follow-up. The DON and administrator will receive reports of weekly audit. Any staff identified as not following the Bowel Management policy and procedure and/or physician's order will be re-educated and/or counseled as necessary. After the 3-month period, QAA Committee will re-evaluate the frequency of the audit.

DON and Administrator will review an aggregate analysis of the QA Audit Reports and report monthly findings to the QAA Committee.

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F 309	Continued From page 13 Continued review of the clinical record produced Resident #13's bowel movements. Review of Resident #13's bowel movements failed to document a bowel movement for Resident #13 on June 28th, June 29th, June 30th, July 1st, July 2nd, July 3rd and July 4th. Further review of the clinical record produced the nursing notes for Resident #13 from June 28, 2017 through July 4, 2017. Review of the nursing notes failed to produce documentation of an assessment of Resident #13's abdomen to include palpation and assessment of bowels. Continued review of the clinical record produced the June and July 2017 Medication Administration Records (MAR's). The June and July 2017 MAR's documented that the facility staff administered MOM 30 ml's on July 3, 2017. The surveyor noted that Resident #13 did not have a bowel movement after the administration of the MOM on 7/3/17. There was no documentation of assessment of Resident #13's bowels, notification to the physician for further treatment or administration of the Dulcolax suppository or another dose of MOM. The surveyor noted that Resident #13 had gone 7 days without having a bowel movement. On July 26, 2017 at 1:50 p.m. the surveyor notified the Director of Nursing (DON) that Resident #13 had gone 7 days without having a bowel movement and that assessment and treatment had not been done by the facility staff. The surveyor reviewed the clinical record with the DON. The surveyor specifically reviewed the physician orders with the DON. The surveyor pointed out the physician orders for MOM 30 ML's every 24 hours as needed for constipation and	F 309	QAA Committee will monitor reports monthly for patterns and trends and recommend adjustments accordingly. Recommendations will be reviewed quarterly by the Medical Director, QAA Committee, DON and Administrator.	

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F 309	Continued From page 14 Dulcolax Suppository one time daily for constipation. The surveyor then reviewed Resident #13's bowel movement document with the DON. The surveyor pointed out that Resident #13 did not have a bowel movement from June 28th through July 4, 2017, a total of seven days. The surveyor then reviewed the June and July 2017 MAR's and the nurses' notes with the DON. The surveyor notified the DON that the facility had not assessed Resident #13's abdomen for bowel sounds nor had the facility staff administered the physician ordered as needed medications. The DON stated she would look into the matter and be back in touch with the surveyor. On July 26, 2017 at 2:45 p.m. the DON approached the surveyor and stated, "I have nothing." The DON hand delivered a facility document that identified that Resident #13 was on the BM "Audit" list on 7/3/17 and 7/5/17. No additional information was provided to the surveyor as to why the facility staff failed to assess, monitor and treat Resident #13's constipation and lack of bowel movements over the seven day period from June 28th through July 4, 2017. On July 26, 2017 at 3:10 p.m. the survey team met with the Administrator (Adm), DON, Quality Assurance Nurse (QAN) and the Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #13 had gone 7 days without having a bowel movement. The surveyor notified the AT that the facility staff had not monitored, assessed or treated Resident #13 constipation/lack of bowel movement. No additional information was provided prior	F 309		

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F 309	Continued From page 15 to exiting the facility as to why the facility staff failed to monitor, assess and treat Resident #13's constipation lack of bowel movements for 7 days.	F 309		
F 333 SS=E	RESIDENTS FREE OF SIGNIFICANT MED ERRORS CFR(s): 483.45(f)(2) 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, facility staff failed to hold medication per ordered parameters for 1 of 25 residents in the survey sample (Resident #22). Resident #22 was admitted to the facility on 5/19/15 with diagnoses including diabetes mellitus, Parkinson's disease, hypertension, and major depression. On the significant change minimum data set assessment (MDS) with assessment reference date 2/16/17, the resident was assessed with short and long term memory deficits and impaired ability to make daily decisions and with symptoms of delirium and physical and verbal behavior symptoms. January 2017 record review revealed: A nurse's note dated 1/1/17 at 11:46 AM documented that the resident had been 'placed on rounds per on call provider for BG [blood	F 333	Resident #22 Correction: Resident #22 expired on 4/06/17 Potential Residents: The medical records of all current residents with a physician's order for insulin with a hold parameter will be reviewed for the previous 8 weeks for appropriate insulin administration. Systematic Changes: The QAA Committee will review and revise as necessary the policy and procedure for Insulin Administration. Physician orders for insulin administration with hold parameters will be transcribed into Point Click Care using a sliding scale	9/8/17

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glucose] review". Nurse's notes on 1/8/17 documented that the resident's insulin orders had changed. Lantus Solution 100 unit/ml (milliliter) Inject 45 unit subcutaneously at bedtime for diabetes was increased to Lantus Solution 100 unit/ml (milliliter) Inject 50 unit subcutaneously at bedtime for diabetes. The order for Novolog Solution 100 unit/ml Inject 15 unit subcutaneously with meals for diabetes should be given immediately before (10-15 min) a meal or as late as 15 min after the start of the meal was decreased to Novolog Solution 100 unit/ml Inject 10 unit subcutaneously with meals for diabetes HOLD NOVOLOG IF BLOOD SUGAR LESS THAN 180. The MAR indicated that The resident's blood sugar was less than 180 27 times in February 2017. The MAR documented that Novolog 10 units was held 11 times. Nurse's notes documented that the insulin was held 5 additional times. The MAR indicated that the resident received insulin -and injection location- when the blood sugar was less than 180 on 1/14 at 5 PM with a blood sugar of 134, 1/16 at 8 AM with a blood sugar of 108, 1/16 at 12 PM with a blood sugar of 164, 1/16 at 5 PM with a blood sugar of 166, 1/21 at 5 PM with a blood sugar of 168, 1/27 at 8 AM with a blood sugar of 120, 1/27 at 5 PM with a blood sugar of 177, 1/27 at 8 AM with a blood sugar of 120, 1/28 at 12 PM with a blood sugar of 124, 1/28 at 5 PM with a blood sugar of 91, 1/29 at 8 AM with a blood sugar of 162, 1/29 at 5 PM with a blood sugar of 146, and 1/31 at 8 AM with a blood sugar of 107.

The surveyor discussed concerns with the resident's care with the administrator and director of nursing on 7/27/17.

CONCLUSION: SUBSTANTIATED DUE TO

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order template.

Nurses will be inserviced on the policy and procedure for Insulin Administration and transcribing insulin orders with hold parameters into Point Click Care.

Monitoring:

The QA Coordinator or designee will select 50% of current residents with a physician's order for insulin with hold parameters and conduct a QA audit weekly for 12 weeks using the Insulin Administration audit tool to identify any resident who may have received insulin with a blood sugar outside of the established range. The DON and administrator will receive reports of weekly audit. Any staff identified as not following the physician's order for insulin administration will be re-educated and/or counseled as necessary. After the 3-month period, QAA Committee will re-evaluate the frequency of the audit.

DON and Administrator will review an aggregate analysis of the QA Audit Reports and report monthly findings to the QAA Committee.

QAA Committee will monitor reports monthly for patterns and trends and recommend adjustments accordingly.

Recommendations will be reviewed quarterly by the Medical Director, QAA Committee, DON and Administrator.

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F 333	Continued From page 17 FAILURE TO OBTAIN AN ORDERED LABORATORY TEST.	F 333		
F 502 SS=D	ADMINISTRATION CFR(s): 483.50(a)(1) (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, clinical record review and facility document review, and in the course of a complaint investigation facility staff failed to obtain a physician ordered laboratory test for 2 of 25 residents in the survey sample (Residents #22 and #10). 1. For Resident #22, facility staff failed to obtain a physician-ordered urinalysis. Resident #22 was admitted to the facility on 5/19/15 with diagnoses including diabetes mellitus, Parkinson's disease, hypertension, and major depression. On the significant change minimum data set assessment (MDS) with assessment reference date 2/16/17, the resident was assessed with short and long term memory deficits and impaired ability to make daily decisions and with symptoms of delirium and physical and verbal behavior symptoms. While investigating a complaint that facility staff had failed to obtain a urinalysis in March 2017, the surveyor was unable to locate an order or results for a urinalysis in March. During an	F 502	Resident #22 and Resident #10 Correction: Resident #22's Unit Manager was disciplined and re-educated on the Lab Monitoring policy and procedure and proper monitoring of the Unit Lab Book on 4/03/17. Resident #22's physician was notified. Resident #10's physician order for occult blood stools was discontinued on 5/09/17. Potential Residents: The medical records of all current residents will be reviewed for completion of urinalysis and occult blood stools according to physician's orders for the past three (3) months. Physician and resident representative will	9/8/17

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F 502	Continued From page 18 interview on 7/27/17, the director of nursing and administrator confirmed that there was an order for laboratory tests including a urinalysis dated 3/13/13. The urinalysis was not obtained. This is complaint deficiency. 2. For Resident #10 the facility staff failed to obtain physician ordered stool specimens for occult blood ordered on 4/18/17. Resident #10 was a 73 year old female who was admitted on 3/16/16. Admitting diagnoses included, but were not limited to: hypothyroidism, urinary tract infection, hypertension, fractured humerus, depression and dementia without behaviors. The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 6/29/17. The facility staff coded that Resident #10 had a Cognitive Summary Score of 9. The facility staff also coded that Resident #10 required set up (2/2) to total nursing care (4/2) with Activities of Daily Living (ADL's). On July 26, 2017 at 10:20 a.m. the surveyor reviewed Resident #10's clinical record. Review of the clinical record produced a physician order dated 4/18/17 that read, "Check stools for occult blood X (times) 3 samples." (sic) Continued review of the clinical record produced the results of one stool sample dated 4/25/17 that documented that the stool specimen was negative for occult blood. Continued review of the clinical record failed to produce documentation that the facility staff had obtained the other two stool specimens.	F 502	be notified of any urinalysis and/or occult blood labs that have not been completed as ordered. Systematic Changes: The QAA Committee will review and revise as necessary the policy and procedure for Lab Work Monitoring. Nurses will be inserviced on the policy and procedure for Lab Work Monitoring. When a physician's order is obtained for occult blood stools, a Miscellaneous Lab result sheet will be placed in the Unit Lab Book until the results are completed. The Charge Nurse will notify the CNA of the need for stool collection on the daily CNA Assignment sheet. When a physician's order is obtained for occult blood stools, a reminder will be placed on the MAR. The reminder will be signed off each shift by the Charge Nurse until all occult blood stools are collected. The Unit Manager or designee will review the Unit Lab Book daily to ensure all urinalysis and occult blood stools are completed as ordered. Monitoring: The QA Coordinator or designee will select 10% of current residents and conduct a QA audit weekly for 12 weeks	

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F 502	Continued From page 19 Further review of the clinical record produced the Bowel Movement records for Resident #10. The surveyor reviewed the document. The surveyor noted that Resident #10 had a bowel movement on 4/21/17 at 9:39 p.m. and on 4/22/217 at 2:31 p.m. and 8:44 p.m. The surveyor noted that Resident #10 did have additional bowel movements prior to 4/25/17 that could have been checked for occult blood. On July 27, 217 at 11:10 a.m. the surveyor notified the Unit Manager (UM), who was a Registered Nurse (RN), that Resident #10 had physician order to obtain stool specimens (3) and to check the stool specimens for occult blood. The surveyor reviewed the clinical record with the UM and specifically pointed out the physicians order to obtain stool specimens X 3 and to check for occult blood. The surveyor notified the UM that review of the clinical record only produced the results (dated 4/25/17) of one stool specimen that was checked for occult blood. On July 27, 2017 at 3:10 p.m. the survey team met with the Administrator (Adm), Director of Nursing, Quality Assurance Nurse (QAN) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #10 had a physician order, dated 4/18/17, to obtain three stools specimens and to check for occult blood. The surveyor notified the AT that review of the clinical record only produced the result of one stool specimen checked for occult blood and it was dated 4/25/17. The surveyor notified the AT that the facility staff failed to obtain the physician ordered stools for occult blood for Resident #10. No additional information was provided to the	F 502	using the Lab Monitoring audit tool to identify any urinalysis or occult blood stool tests not performed according to physician's order. The DON and administrator will receive reports of weekly audit. Any staff identified as not following the physician's order for obtaining urinalysis and/or occult blood stools will be re-educated and/or counseled as necessary. After the 3-month period, QAA Committee will re-evaluate the frequency of the audit. DON and Administrator will review an aggregate analysis of the QA audit reports and report monthly findings to the QAA Committee. QAA Committee will monitor reports monthly for patterns and trends and recommend adjustments accordingly. Recommendation will be reviewed quarterly by the Medical Director, QAA Committee, DON and administrator.	

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F 502	Continued From page 20 survey team prior to exiting the facility as to why the facility staff failed to obtain physician ordered labs.	F 502		