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| SENTARA WOODVIEW | 103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592 |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 05/03/16 through 05/05/16. Corrections are required for compliance with 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 216 certified bed facility was 182 at the time of the survey. The survey sample consisted of 25 current Resident reviews (Residents # 1 through 25) and three closed record reviews (Residents # 26 through 28). | F 000 | | |
| F 250 SS=D | PROVISION OF MEDICALLY RELATED SOCIAL SERVICE<br>CFR(s): 483.15(g)(1)<br><br>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on family interview, staff interview and clinical record review the facility staff failed to provide medically related social services to three of 28 residents, Resident #8, Resident #18 and Resident #23.<br><br>1. Resident #8 did not have a physician ordered behavioral health evaluation scheduled.<br><br>2. Resident #17 did not have a dental appointment scheduled per the RP's(responsible | F 250 | Corrective Action:<br><br>On May 3, 2016 an appointment was made with the Southside Community Services Board for Resident #8 to be evaluated and treated. The appointment is scheduled for June 22, 2016 at 9:30 a.m.<br><br>Resident #17 had a dentist appointment and was seen by the dentist on May 6, | 6/7/16 |

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

Electronically Signed | 05/19/2016

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| F 250 | Continued From page 1<br>party's) request.<br><br>3. Resident #23 did not have a physician ordered psychiatric evaluation scheduled.<br><br>Findings were:<br><br>1. Resident #8 did not have a physician ordered behavioral health evaluation scheduled.<br><br>Resident #8 was most recently readmitted to the facility on 03/22/2016. His diagnoses included but were not limited to: hypertension, end stage renal disease, diabetes mellitus, and ischemic heart disease.<br><br>The most recent MDS (minimum data set was a significant change assessment with an ARD (assessment reference date of 03/28/2016. Resident #8 was assessed as having a cognitive summary score of "15", indicating he was cognitively intact.<br><br>The clinical record was reviewed on 05/03/2016. Observed in the physician's order section was the following order dated 04/20/2016: "Please schedule appt [appointment] with Behavioral Health to evaluate & treat complaint of anxiety and hallucinations." Further review of the clinical record did not reveal any documentation that behavioral health had been contacted to set up an appointment nor was there any documentation that an evaluation had occurred.<br><br>The clinical manager, RN (registered nurse) #5 was interviewed on 05/03/2016 regarding the appointment. She stated, "They are working with the community service board to get an | F 250 | 2016.<br><br>Resident #23 has a Psychiatric consult appointment scheduled for June 9, 2016.<br><br>Social workers were re-educated regarding timeliness of reviewing Social Services Alert Sheets.<br><br>Identification:<br><br>On May 11, 2016 a facility-wide chart audit was performed by the Quality Improvement Coordinator to identify other residents in the facility who had orders for Mental Health Services or Dental Services or who had requested these services over the past year to ensure appropriate follow-up. There were no other medical related Social Services needs identified that had not been followed up on.<br><br>Changes:<br><br>1. The Social Services Alert Sheet was reviewed and revised to improve communication and tracking of new orders for resident social service needs.<br><br>2. Social Workers and Licensed Nursing Staff will be re-educated on the procedure for ensuring that physician orders for mental health services and dental services and family/resident requests for these services are followed-up on in a timely manner.<br><br>Monitoring: | |

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| F 250 | Continued From page 2<br>appointment." She was asked if the social worker at the facility scheduled those appointments. She stated, "Yes." RN #5 was asked to check on the status of the physician ordered appointment and let this surveyor know if an appointment had been obtained.<br><br>On the morning of 05/04/2016, RN #5 reported that the social worker was waiting on a call from the community service board regarding the appointment. RN #5 was asked why the appointment had not already been scheduled. She stated, "I think it had something to do with him being on a stretcher, but now he can go in a wheelchair." She stated she would have the social worker come speak with this surveyor.<br><br>On 05/04/2016 the social worker (Other staff #3) came to the conference room to speak with this surveyor regarding Resident #8's behavioral health evaluation. She stated that an appointment had been scheduled for 06/03/2016 at 2:00 p.m. The social worker was asked when the appointment had been scheduled. She stated, "Yesterday." The social worker was asked why the appointment had not been made prior to 05/03/2016 when the order had been written on 04/20/2016. She stated, "I was trying to get information together for the community service board, they need a lot of background information on the behaviors and why we are making a referral...I was getting that together." She was asked how long it usually took to get the needed information together. She stated, ...I am an hourly employee, I work 40 hours a week and I have 60 hours of work to do every week...I have to prioritize what is on my desk...I hadn't gotten to this yet...this is my fault...write me up." The social worker was asked if there was documentation | F 250 | The Admissions/Social Services Director or designee will perform weekly audit of physician orders on 54 charts (25% of total beds) to identify physician orders written during the previous month for mental health services and dental services and to monitor for follow-up.<br><br>In addition, a weekly Social Services Alert Sheet Audit will be performed by the Social Services Director or designee to monitor follow-up of family requests and/or physician orders for mental health services and dental services.<br><br>Findings of these audits will be reported to the Quality Assurance Performance Improvement (QAPI) committee quarterly and the committee will determine when the audits will be discontinued. | |

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regarding what she had been doing to get the appointment. She stated, "I keep a file in my office. The social worker was asked if this surveyor could see the file. She presented a file containing copies of nurse's notes, a physician evaluation and order for the evaluation. A fax cover sheet was observed in the file. The cover sheet was addressed to the local CSB and contained the following but not limited to: "Needs counseling appt Surveyors are here and we need an appt. please. He is alert oriented in a wheelchair and able to take care of his ADL's [activities of daily living]." The social worker was asked if the CSB had been contacted prior to 05/03/2016. She stated, "No, I contacted them yesterday."
She was asked if the doctor had been notified of the delay in obtaining the evaluation. She stated, "No, I do the best I can with what I have to do."
She was asked if she had communicated to her supervisor that she was unable to get her work completed. She stated, "Yes, I told [names of her two supervisors], they both know...it's my fault. You can write me up."

At approximately 9:30 a.m., this surveyor went to the nurse's station. The Social Services Supervisor, Other Staff #1 was also in the nurse's station. The conversation held with in the conference room was discussed.

The above information was discussed with the DON (director of nursing) and the administrator during an end of the day meeting on 05/04/2016.

On 05/05/2016 at approximately 8:30 a.m., the Social Services Director came to the conference room. She presented a form that had been revised to assist the social services department

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to make sure needed services were provided in a timely manner.

No further information was obtained prior to the exit conference on 05/05/2016.

2. Resident #17 did not have a dental appointment scheduled per the RP's(responsible party's) request.

Findings were:

Resident #17 was admitted to the facility on 11/21/2010 with the following diagnoses, but not limited to: hypertension, diabetes mellitus, cerebral vascular disease, congestive heart failure, renal insufficiency, degenerative joint disease, peripheral vascular disease and morbid obesity. Resident #17 was also diagnosed as being legally blind.

The most recent MDS (minimum data set was an annual assessment with an ARD (assessment reference date of 02/22/2016. Resident #17 was assessed as having a cognitive summary score of "09", indicating moderate impairment with his cognitive status.

Initial tour of the facility was conducted on 05/03/2016 at approximately 1:30 p.m. Resident #17's wife, his responsible party was in his room and spoke with this surveyor. During the conversation she stated that Resident #17 had not seen a dentist in over a year. She stated that she had discussed this with the staff but had not gotten any results.

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On the morning on 05/04/2016 this surveyor asked an LPN (licensed practical nurse) in the nurse's station if dental services were available at the facility. She stated, "Yes, we have a dentist that comes here."

At approximately 2:30 p.m., Resident #17's RP was observed in his room. This surveyor told her that a dentist came to the facility. She stated, "[Name of social worker-other staff #5] was in the last care plan meeting, I bring this up in every one of them, she said there was no dentist that came here and because he has to go on a stretcher there is no one to see him....his crown came off of his tooth over a year ago, and it is very hard to get his teeth clean, he has a lot of build up on them."

This surveyor went to the nurse's station and spoke with the clinical manager, RN (registered nurse) #5. The LPN who had stated there was a dentist that came to the facility was also in the nurse's station. This surveyor asked for clarification. RN #5 stated, "No, we did have one that came from the clinic but because they got so busy they don't come here any more." RN #5 was asked if she was aware that Resident #17 had lost a crown from one of his teeth over a year ago. She stated, "No, I was not aware of that." RN #5 was asked who made the appointments for dental work. She stated, "social services."

At approximately 3:15 p.m., the social services supervisor-other staff #1 and the DON (director of nursing) came to speak with this surveyor regarding Resident #17. Concerns were voiced that Resident #17's RP was requesting dental services for Resident #17 and was unable to get

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an appointment for him. The social services supervisor stated that the dental clinic had been contacted and they would not see the resident there because he was unable to get in their chair. She was asked if there were other dentists in the area who would see him or if anyone else had been contacted. She stated she would look into it.

At approximately 3:50 p.m., the social services supervisor came to the conference room and stated that an appointment had been made for Resident #17 to be seen in the dental clinic on 08/09/2016. She and the DON stated that the dentist had not been in when the appointment had been made and they would need to check back with her on the following day (05/05/2016) to make sure that she approved of the resident to be seen there. The social services supervisor stated, "[Name of Other staff #3] called and attempted to get the appointment after the care plan meeting in September. She told the RP that he would need to be able to get into the dental chair and since he could not transfer there was no other availability for him." The supervisor was asked if she felt that all possibilities for an appointment with a dentist, other than the dental clinic had been explored. She stated, "No."

On 05/05/2016 at approximately 9:00 a.m., RN #5 came to the conference room and stated that the dentist had been contacted that morning and she had agreed to come to the facility on 05/12/2016 at 09:00 a.m. to see Resident #17.

No further information was obtained prior to the exit conference on 05/05/2016.

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3. Facility staff failed to obtain a physician ordered psychiatric evaluation for Resident #23.

Resident #23 was originally admitted to the facility 10/31/2008 and readmitted on 03/27/2013 with diagnoses including, but not limited to: Hypertension, Peripheral Vascular Disease, Diabetes, Dementia, Anxiety, Cataracts and Dysphagia.

The most recent MDS (minimum data set) was an annual assessment with and ARD (assessment reference date) of 04/12/2016. Resident #23 was assessed as cognitively intact with a total cognitive score of 15 out of 15.

Resident #23's clinical record was reviewed on 05/04/2016 at 3:20 p.m. During this review two physician orders were noted that stated the following, "3/31/16 ...3) Psych consult to eval (evaluate) psychogenic cough." The second order dated "4/7/16" stated, "...2) Please schedule psych eval as previously ordered to evaluate psychogenic cough."

Under the consultation tab in the clinical record a "Consultation Request" to the pulmonary doctor, dated 3/17/16, included the following recommendation, "...3) rec: Psych consult for psychogenic causes of cough..." The "Consultation Report" was noted by the LPN (licensed practical nurse) on duty at the facility on "3-17-16." The same report was noted by the NP (nurse practitioner) on "3/18/16."

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A physician progress note dated 4/7/2016 included the following documentation, "...Assessments...has been seen by Dr. (doctor) (Name) to evaluate cough and clearing throat. It was recommended to have psych eval for possible psychogenic cough...Plan...psych eval..." This note was signed by the NP.

"Nurse's Notes" included the following entries, "3/31/16 12:30p (12:30 p.m.) New order...3) psych consult to eval pschogenic (sic) cough..." The second note dated "4-7-16 6:50 p.m. (Name) FNP (family nurse practitioner) seen resident for recert...2) Please schedule psych eval as previously order (sic) to evaluate psychogenic cough..."

Under the Social Work tab in the clinical record was a "Social Services Quarterly Progress Note" dated "4/12/2016." Page five of this assessment included the following documentation, "Mental Health Services Provided or Arranged during the quarter if needed: Yes N/A." N/A (not applicable)was checked. Also under this tab was a "(Name) Community Services Board Confidential Individual Referral/Needs Assessment Form." This form had been completed by the Social Worker (Other #1). No date was included on the form, but an attached fax sheet was dated "4/13/16 4:00 p.m." The section on the form "Presenting problem (s):" included, "Physicians Order: Psych consult for psychogenic causes of cough."

On 05/04/2016 at 4:15 p.m., Other #1 was interviewed regarding why it had taken so long to initiate this referral. Other #1 stated, "We have been having a lot of problems with CSB

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(Community Services Board) getting appointments because they are slammed." Other #1 then proceeded to take a binder off the bookshelf and pulled out a "Social Services Alert Sheet" for Resident #23. This sheet was dated "3/31/16 at 2:30 p.m." Marked on the sheet was, "Needs a Mental Health Appointment...Explanation / Comments: Dr. (Name) recommended psych eval d/t (due to) psychogenic cough. Signature and Title of Staff Completing Form: (Name) LPN (licensed practical nurse) Date Received by Social Worker: 3/31/16." Other #1 stated, "The normal process is a copy of the order is attached to a Social Service Alert Sheet. This is the only sheet I received."

At approximately 4:20 p.m. Other #2 was interviewed regarding the above physician order and referral. Other #2 stated, "I was unaware of this referral. There is a process in place. Make a copy of the order and attach to a Social Service Alert Sheet."

RN #3 (registered nurse) was interviewed at approximately 4:40 p.m. regarding the consult sheet. RN #3 stated, "Nurse noted recommendation on 3/17/16. She would place consult sheet in the physician's communication basket. Nurse practitioner noted recommendation on 3/18/16. When the consult sheet is noted by the doctor or the NP it then becomes an order. A copy of the order is then sent to social work."

At approximately 4:45 p.m., RN #3 telephoned the nurse who had noted the physician order on 3/31/16. That nurse is identified as LPN #1. RN #3 entered the conference room and placed LPN

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| F 250 | Continued From page 10<br>#1 on speaker phone. This surveyor asked why there had been another order written for a Psych consult on 3/31/16 since the consult sheet had become an order on 3/18/16. LPN #1 stated, "Resident was having a pretty rough day yelling out. I talked to the NP and she said to go on with the recommendation for a Psych consult. That is why I wrote the second order."<br><br>Other #2 was again interviewed at 4:55 p.m. and was asked how social work receives consults. Other #2 stated, "Consults / orders are placed in a social worker mailbox unless they are handed directly to a social worker."<br><br>At 5:00 p.m. Other #1 was interviewed regarding the multiple physician orders for a Psych consult for Resident #23. Other #1 stated, "I was unaware (Name) NP signed the order on the 18th (March). The only alert sheet I received was on the 31st (March). I returned to work on the 11th (April) from my son's surgery and somewhere during that week I was made aware of the order written on the 7th (April) and I faxed everything on the 13th (April)." This surveyor was informed that Resident #23 has a Psych appointment scheduled on June 9th.<br><br>The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 05/04/2016 at approximately 5:00 p.m.<br><br>No further information was received by the survey team prior to the exit conference on 05/05/2016. | F 250 | | |
| F 280 SS=D | RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br>CFR(s): 483.20(d)(3), 483.10(k)(2) | F 280 | | 6/7/16 |

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| F 280 | Continued From page 11<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, facility staff failed to review and revise a CCP (comprehensive care plan) for one of 28 residents in the survey sample, Resident #5.<br><br>Facility staff failed to review and revise Resident #5's CCP in March 2016 along with her annual MDS (minimum data set) assessment.<br><br>Findings included:<br><br>Resident #5 was admitted to the facility on 02/16/2014 with diagnoses including, but not limited to: Dementia, Sick Sinus Syndrome with | F 280 | Corrective Action:<br><br>The Comprehensive Care Plan (CCP) was reviewed and revised on May 4, 2016 for Resident #5.<br><br>Identification:<br><br>All residents' care plans were reviewed (100%) for revisions and up-dates. There were no areas of non-compliance.<br><br>Changes: | |

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| | 495372 | A. BUILDING _____ B. WING _____ | 05/05/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SENTARA WOODVIEW | 103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592 |

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| F 280 | Continued From page 12<br>Pacemaker Placement, Hypothyroidism, Hypertension, Depression, Neurogenic Bladder and Chronic Kidney Disease-Stage III.<br><br>The most recent MDS was an annual assessment with an ARD (assessment reference date) of 03/08/2016. Resident #5 was assessed as moderately impaired in her cognitive status with a total cognitive store of 10 out of 15.<br><br>Review of Resident #5's clinical record occurred on 05/04/2016 at 8:05 a.m. During this review Resident #5's CCP was noted as last updated on 12/28/2015, with a goal date of 03/28/2016.<br><br>At 8:55 a.m., RN #3 (registered nurse) was interviewed regarding who updates the CCP's on her unit. RN #3 stated, "I have a set of rooms and MDS has a set of rooms. This is not one of my rooms."<br><br>RN #4 (MDS) was interviewed at 10:00 a.m. regarding why Resident #5's CCP had not been updated since December 2015. RN #4 stated, "We had a care plan meeting for another resident before her (Resident #5) care plan meeting. We then had hers (Resident #5). I usually update the care plan as we go along, but on that day a family member for the previous resident showed up and we reviewed her care plan again and I just forgot to go back and update the dates."<br><br>The Administrator and DON (director of nursing) were informed of the above during a meeting with survey team on 05/04/2016 at approximately 5:00 p.m.<br><br>No further information was received by the survey team prior to the exit conference on 05/05/2016. | F 280 | Each Interdisciplinary Care Plan Team (IDCP) member will initial the care plan sign-in sheet at the conclusion of each ID Care Plan conference, indicating that the care plans were reviewed and up-dated. The IDCP team will be educated by the Director of Nursing on this new process.<br><br>Monitoring:<br><br>Weekly, using the MDS schedule, the MDS Coordinator or designee will review the care plans of residents whose care planning conference was held that week, to ensure that each comprehensive care plan has been updated. All findings will be reported to the Director of Nursing who will report the findings to the QAPI committee quarterly. The QAPI committee will determine when the audits will be discontinued. | |

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| F 328 SS=D | TREATMENT/CARE FOR SPECIAL NEEDS CFR(s): 483.25(k)<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review, the facility staff failed to ensure oxygen was administered per physician's order for one of 28 residents in the survey sample, Resident # 12.<br><br>Resident # 12 was ordered oxygen at 1 LPM (1 liter per minute) via nasal cannula, as ordered by the physician; the resident was observed with oxygen at 4 LPM on two separate occasions.<br><br>Findings include:<br><br>Resident # 12 was admitted to the facility on 06/21/12, with the most current readmission on 07/20/15. Diagnoses for Resident # 12 included, but were not limited to: senile dementia, DM (diabetes mellitus), CHF (congestive heart failure), HTN (hypertension/high blood pressure), acute and chronic respiratory failure with hypoxia and/or hypercapnia. | F 328 | Corrective Action:<br><br>On May 6, 2016, Resident #12's oxygen flow rate was adjusted to 1 liter per minute as ordered per physician .<br><br>Identification:<br><br>On May 6, 2016, all residents receiving oxygen via nasal cannula were checked to determine if the oxygen flow rate was being administered as ordered. There were no residents that were receiving oxygen via nasal cannula with an incorrect flow rate.<br><br>Changes:<br><br>The physician ordered oxygen flow rate will be written on the oxygen humidifier bottle of each resident as a reminder of the correct amount of oxygen to be | 6/7/16 |

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| F 328 | Continued From page 14<br>The most current MDS (minimum data set) was a quarterly assessment dated 02/23/16. This MDS assessed the resident with a cognitive score of "4", indicating that the resident had severe impairment in daily decision making skills. The resident was also assessed as requiring oxygen in the previous 14 days, in Section O. Respiratory Treatments C. oxygen therapy, on this MDS.<br><br>On 05/03/16 at approximately 3:15 p.m., Resident # 12 was observed in her room, sitting in a recliner with her legs elevated. The resident had a nasal cannula on, with an oxygen concentrator located behind the resident's recliner. The resident's oxygen concentrator was observed. The resident's oxygen was set on 4 LPM (liters per minute) via NC (nasal cannula).<br><br>Resident # 12's clinical record was reviewed on 05/04/16 at approximately 10:00 a.m. The resident's current POS (physician's order set) dated 05/01/16 through 05/31/16 included an order for, but not limited to: "...O2 [Oxygen] at 1 L [liter]/min [minute] via NC [nasal cannula] 24/7..."<br><br>On 05/04/16 at approximately 11:30 a.m., Resident # 12 was observed again in her room, sitting in a recliner with legs elevated and nasal cannula in place. The resident's oxygen concentrator was observed again. The resident's oxygen was set on 4 LPM via NC.<br><br>The resident's CNA (certified nursing assistant) (CNA # 1) was found and interviewed at approximately 11:35 a.m. CNA # 1 was asked if they (CNA's) check the resident's oxygen, the CNA voiced that sometimes they (CNA's) will check oxygen saturation. The CNA was asked about the actual oxygen setting on the oxygen | F 328 | administered to that resident. Writing the oxygen flow rate on the humidifier bottle will be part of the process when noting a physician order. In addition, the new process includes writing the flow rate on the humidifier bottle each time the humidifier bottle is changed. Licensed nurses will be educated by the Director of Nursing on this new process.<br><br>Monitoring:<br><br>The 3-11 shift RN supervisor will check the oxygen flow rate for each resident during routine rounds on a weekly basis and will inform the charge nurse to correct any non-compliance at the time of the findings. The supervisor monitoring rounds will document findings on an oxygen flow auditing tool and findings will be tracked and trended. Findings will be reported at the QAPI committee meeting on a quarterly basis by the Director of Nursing. The QAPI committee will determine when the audits will be discontinued. | |

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concentrator. The CNA voiced that they (CNA's) do not adjust any settings on the oxygen, and further voiced that the nurse's do that. The CNA was then asked if she knew what Resident # 12's oxygen setting was suppose to be. The CNA voiced that she thought it was suppose to be one, but wasn't completely for sure. The CNA looked at the resident's oxygen concentrator and observed the oxygen setting on 4 LPM. The CNA again voiced that they (CNA's do not adjust oxygen settings).

At approximately 11:45 a.m., RN (Registered Nurse) # 2 was interviewed regarding Resident # 12's oxygen and was asked who is responsible for checking the oxygen settings. The RN voiced, that she was responsible and further voiced that she had not checked it today. The RN was asked to observe Resident # 12's oxygen concentrator settings. RN # 2 looked at the oxygen concentrator and was then asked what Resident # 12's oxygen setting was suppose to be. RN # 2 voiced, that she thought it was suppose to be 1 liter per minute, but would double check the physician's orders to be certain.

The RN then verified with the resident's physician's orders that the oxygen was supposed to be set a 1 LPM. The RN voiced uncertainty as to why the oxygen concentrator setting was set to 4 LPM and was uncertain as to how long it had been at 4 LPM. The RN was made aware that the resident had been observed the evening before and this morning with the oxygen level at the same setting, 4 LPM.

Resident # 12's CCP (comprehensive care plan) was then reviewed and documented, "...risk for acute SOB [shortness of breath]...CHF, 02 use,

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| F 328 | Continued From page 16<br>chronic respiratory failure...O2 at 1 liter per minute via nasal cannula..."<br><br>The administrator and DON (director of nursing) both were informed of the above information in a meeting with the survey team on 05/04/16 at approximately 5:30 p.m., no comment was made by either.<br><br>No further information or documentation was presented prior to the exit conference on 05/05/16. | F 328 | | |
| F 502 SS=D | ADMINISTRATION<br>CFR(s): 483.75(j)(1)<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, facility staff failed to obtain a physician ordered lab for one of 28 residents in the survey sample, Resident #2.<br><br>Facility staff failed to obtain a Lipid Profile in February 2016 for Resident #2.<br><br>Findings included:<br><br>Resident #2 was admitted on 02/11/2014 with diagnoses including, but not limited to: Hypertension, Diabetes Mellitus, Dementia, Glaucoma, Dysphagia, Congestive Heart Failure and Anemia. | F 502 | Corrective Action:<br><br>The Nurse Practitioner (NP) was notified that the lipid profile was missed in February 2016 and a new order was obtained for the lipid profile to be obtain on May 6, 2016. The responsible party was notified of the missed lab and the blood was drawn and the results obtained on May 6, 2016.<br><br>Identification:<br><br>The physician orders for all residents with orders for lipid profiles for the past six (6) | 6/7/16 |

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| F 502 | Continued From page 17<br><br>The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/01/2016. Resident #2 was assessed as severely impaired in her short and long term memory and daily decision making skills.<br><br>Resident #2's clinical record was reviewed on 05/03/2016 at 4:35 p.m. The current POS (physician order sheet) included an order for a Lipid Profile lab every six months in February and August. Results the February Lipid Profile were not located in the clinical record.<br><br>On 05/04/2016 at 8:00 a.m., RN #3 (registered nurse) was interviewed regarding the Lipid Profile results. RN #3 and this surveyor reviewed lab results for Resident #2 on the computer. No Lipid Profile results were located. RN #3 made a call to the lab and asked to have the original lab order slip from February faxed to the facility.<br><br>At approximately 3:15 p.m., RN #3 approached this surveyor in the hallway and stated, "Lipids was not marked on the lab slip for February so it was not obtained. I called the doctor and we got it today."<br><br>The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 05/04/2016 at approximately 5:00 p.m.<br><br>No further information was obtained by the survey team prior to the exit conference on 05/05/2016. | F 502 | months were reviewed to determine if results were present on the chart. All of the ordered lipid profile results were on the charts.<br><br>Changes:<br><br>All lab request slips will be reviewed by two staff members to ensure that the correct tests have been marked on the lab requisition slip before the blood sample is sent to the lab. These two staff members will initial the lab slip prior to submission of the specimen to the lab. Licensed staff will be educated on this new procedure by the Director of Nursing.<br><br>Monitoring:<br><br>Clinical Nurse Managers or designee will check the charts of all residents that have lipid profiles ordered each month to ensure these orders have been carried out and results are on the chart. The audit results will be presented to the Director of Nursing on a monthly basis. The Director of Nursing will review the results, and will present the reports to the QAPI committee on a quarterly basis. The QAPI committee will determine when the audits will be discontinued. | |