STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495338	A. BUILDING _____ B. WING _____	C 11/10/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		12/09/16

An unannounced Medicare/Medicaid standard survey was conducted 11/8/16 through 11/10/16. Two complaints were investigated during the survey. Corrections are required for compliance with 42 CRF Part 483 Requirements for Federal Long Term Care facilities. The Life Safety Code survey/report will follow.

The census in this 120 certified bed facility was 101 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents 1 through 20) and 5 closed record reviews (Residents 21 through 25).

F 155 SS=D 483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES — F 155

The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	12/02/16

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 155	Continued From page 1	F 155		12/09/16

This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, facility staff failed to ensure a complete and accurate DDNR (durable do not resuscitate) for 1 of 25 Residents, Resident #19.

The findings included:

For Resident #19 the facility staff failed to accurately complete a Virginia Department of Health DDNR form. Sections 1 and 2 of the DDNR were not complete.

Resident #19 was admitted to the facility on 09/06/12 and readmitted on 10/14/16. Diagnoses included but not limited to Alzheimer's disease, bipolar disorder, schizophrenia, insomnia, constipation and colon cancer.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/21/16 coded the Resident as 2 out of 15 in section C, cognitive patterns. This is a quarterly MDS.

Resident #19's clinical record was reviewed on 11/10/16. It contained a Virginia Department of Health DDNR form which read in part:

"I further certify that [must check 1 or 2]:
[ ] 1. The patient is CAPABLE of making an informed decision....
[ ] 2. The patient is INCAPABLE of making an informed decision....

If you checked 2 above, check A, B or C below
[ ] A. While capable of making an informed decision, the patient has executed a written

1. Resident #19 is no longer a resident of the facility.

2. A facility wide audit of the Virginia Department of Health DDNR was completed on 11/30/16. Four DDNRs were corrected.

3. The Admissions/Marketing Director was in-serviced 11/28/16 by the Director of Nursing on ensuring all sections of the Virginia Department of Health DDNR are checked and completed.

The Admissions/Marketing Director/designee will complete an audit of the Virginia Department of Health DDNR of 5 resident x 4 weeks, 3 residents x4 weeks, and 1 resident x4 weeks.

4. The Admissions/Marketing Director/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.

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F 155	Continued From page 2 advanced directive which directs that life-prolonging procedures be withheld.... [ ] B. While capable of making an informed decision, the patient had executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf..." [ ] C. The patient has not executed a written advanced directive." Sections 1 and 2 of the DDNR form had not been checked as directed. The concern of the incomplete DDNR form was brought to the attention of the administrative staff during a meeting on 11/10/16 at approximately 1510. No further information was provided prior to exit.	F 155		12/09/16
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157		

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The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review the facility staff failed to notify appropriate agencies of a communicable disease that affected 1 of 25 Residents, Resident #19 and 1 facility staff.

The findings included:

The facility staff failed to notify the Virginia Department of Health that one Resident, Resident #19 and one staff member had contracted the communicable disease scabies.

Resident #19 was admitted to the facility on 09/06/12 and readmitted on 10/14/16. Diagnoses included but not limited to Alzheimer's disease, bipolar disorder, schizophrenia, insomnia, constipation and colon cancer.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/21/16 coded the Resident as 2 out of 15 in section C,

1. Resident #19 is no longer a resident in the facility.

2. A facility wide skin sweep was complete on 12/3/16 by the Director of Nursing, QA Nurse, and Unit Managers to assess for dermatology issues. No other residents were found to be affected.

3. The Chief Nursing Officer in-serviced the Administrator and Director of Nursing on 11/28/2016 regarding proper notification to the Virginia Department of Health of a communicable disease.

The Director of Nursing/designee will complete skin sweeps to identify dermatology issues 5 residents x 4 weeks, 3 residents x 4 weeks, and 1 resident x 4 weeks.

4. The Director of Nursing/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.

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F 157	Continued From page 4	F 157		12/09/16

cognitive patterns. This is a quarterly MDS.

Resident #19's clinical record was reviewed on 11/09/16. It contained a dermatology consult form dated 10/28/16 which read in part "Chief complaint: 1) itching all over-2 months. Assessment: Scabies."

The surveyor spoke with the epidemiologist from the Virginia Department of Health in Richmond on 11/10/16 at approximately 0835 regarding the reporting of scabies. The epidemiologist stated that an initial case of scabies is not considered reportable unless it moves beyond the original host to infect 1 or more individuals. Then it is considered and outbreak and should be reported to the local health department.

The surveyor spoke with the infection control nurse on 11/10/16 at approximately 1030 regarding Resident #19. The surveyor asked the infection control nurse about Resident #19's case of scabies. The infection control nurse stated that scabies was considered an infection. Surveyor asked infection control nurse if any other person in the facility had contacted scabies and the infection control nurse stated that the SW (social worker) had contracted scabies.

The surveyor spoke with the SW on 11/10/16 at approximately 1115. Surveyor asked the SW if she had contracted scabies and the SW stated that she had tested positive for scabies. SW also stated that she believed she had caught it from Resident #19, since she had been in close contact with Resident during the time Resident had scabies. SW worked informed surveyor that approximately 2 weeks prior to Resident testing positive for scabies, it was reported that a family

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F 157	Continued From page 5	F 157		12/09/16

member of the Resident had a confirmed case of scabies.

The surveyor spoke with the interim administrator regarding Resident #19. Surveyor asked if the outbreak of scabies had been reported to the local health department and the interim administrator stated that since it was only one case, it did not need to be reported. Surveyor then asked interim administrator about SW having contracted scabies from Resident #19 and interim administrator stated "SW wasn't actually treated by a physician, we wanted her to see the facility MD, but he was already gone that day. She was treated prophylactically based on her symptoms".

The surveyor spoke with the SW again on 11/10/16 at approximately 1245. Surveyor asked the SW if she had been seen by a physician for scabies and SW stated that the facility MD was gone and she used "Teladoc". SW worker stated that she took a picture of the areas on her skin so the physician could see them. She was diagnosed and prescribed treatment via the telephone.

The concern of not reporting an outbreak of an infectious disease to the appropriate agencies was discussed during a meeting with the administrative team on 11/10/16 at approximately 1515.

No further information was provided prior to exit.

F 164 SS=D 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS — F 164

The resident has the right to personal privacy and confidentiality of his or her personal and clinical

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records.

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.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview the facility staff failed to provide privacy during a group meeting. This meeting was attended by six alert and orientated Residents of the facility.

The findings included.

During a group meeting held on 11/09/16 beginning at approximately 11:00 a.m. two facility staff entered the area disturbing the group

1. No specific resident was identified for this alleged deficient practice.

2. A facility wide audit was complete on 11/30/16 by the Activities Director regarding disruption of group meetings. Two residents voiced concern regarding this alleged deficient practice.

3. Staff were in-serviced 11/28/16 by the Administrator regarding group resident meetings were not to be disrupted.

Do not disturb signs will be posted during resident meetings.

The Activities Director/ designee will audit 5 residents x 4 weeks, 3 residents x 4 weeks, and 1 resident x 4 weeks.

4. The Activities Director/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.

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F 164	Continued From page 7	F 164		12/09/16

meeting.

The group meeting was held in the dining area on side one of the facility.

During this meeting two female facility staff entered the area disturbing the group meeting. Both of these staff people were wearing tan uniforms.

The administrative staff were made aware of the interruptions during meetings with the survey team on 11/09/16 and again on 11/10/16.

On 11/10/16 the facility staff provided the surveyor with a copy of their policy/procedure titled "Residents Rights" this policy/procedure read in part. "...It is our belief that you as a resident have the right to expect certain standards of care and considerations while at our facility. You have the right to...Have your privacy respected by all employees..."

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

F 226 SS=D 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES

F 226

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:

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F 226	Continued From page 8	F 226		12/09/16

Based on staff interview and facility document review, the facility staff failed to verify 2 of 5 new employees professional licenses (employees #2 and #3) and failed to obtain reference checks on 1 of 5 new employees (employee #2).

The findings included.

The facility failed to verify the professional licenses for employee #2 and employee #3 and failed to obtain reference checks for employee #2.

The surveyor reviewed 5 employee records on 11/09/16.

Employee #2 was hired at the facility as a CNA (certified nursing assistant) on 07/12/16. When reviewing employee #2's employee record the surveyor was unable to locate any reference checks. The facility did not verify employee #2's professional license until 09/14/16.

Employee #3 was hired at the facility as an RN (registered nurse) on 09/27/16. The facility had verified the license on 09/27/16. However, the license had an expiration date of 09/30/16. The license wasn't verified again until 11/09/16 the day the surveyor had requested the employee files.

On 11/09/16 at approximately 3:55 p.m. human resource employee #1 verbalized to the surveyor they did not have documentation to indicate employee #2's license had been verified prior to 09/14/16 and did not have any references for employee #2.

When asked about employee #3's professional

1. Employee #3's professional license was verified on 11/09/16.

Employee #2's reference checks were completed on by the HR Director on 12/2/16.

2. A 100% audit of employee files by the HR Director was completed on 11/29/16 for verification of licensure and references. Items missing were corrected immediately.

3. The Administrator in-serviced the HR Director on 11/25/16 regarding obtaining reference checks and license verification before employees begin work.

The HR Director/designee will audit employee files to verify reference checks and license verification on 5 employees x 4 weeks, 3 employees x 4 weeks, and then 1 employee x 4 weeks.

The Administrator will review and sign the audit weekly.

4. The Activities Director/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.

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F 226	Continued From page 9	F 226		12/09/16

license human resource employee #1 stated she had checked the license after it had expired but had not printed out any documentation.

The administrative staff were made aware of the above issues with the employee files during a meeting with the survey team on 11/10/16 at approximately 3:10 p.m.

The facility provided the surveyor with a copy of their policy/procedure titled "ABUSE PREVENTION POLICY & PROCEDURE." This policy and procedure read in part "...Pre-Employment Screening-When a potential new employee is considered for hire, each of the following steps should be taken to assure that the applicant is suitable for hire...Verification of License/Certificate...will be obtained for all applicable positions...Prior Employment References(s)-Reference check(s) of the candidate's prior employment must be conducted by the department director, or designee, hiring the candidate."

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

F 241 SS=D 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

F 241

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

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F 241	Continued From page 10	F 241		12/09/16

Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide dignity during wound care and dated and initialed the dressing after the dressing had been applied to the resident ' s buttocks for 1 of 25 residents (Resident #5). The findings include:

For Resident #5, the facility staff failed to ensure the dignity for the resident when she dated and initialed the wound care dressing after the dressing had been applied to the resident ' s buttocks.

Resident #5 was admitted to the facility 3/17/06 and readmitted on 8/29/16 with diagnoses that included but not limited to high blood pressure, thyroid disorder, heart failure, esophageal reflux disorder, compression, depression, and manic depression.

Resident #5 ' s comprehensive care plan revised 7/15/16 for her cognitive status. Under problem onset it read in part: Resident #5 has cognitive impairments and is at risk for alteration in communication due to dementia and unclear speech. She has short term and long term memory and decision making deficits. She is alert and sometimes able to make her needs known. She communicates best when using simple, direct communication.

A review of Resident #5's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 8/10/16, the facility staff assessed the resident to understand and to usually be understood. She was assessed to have a cognitive summary score of 03.

On 11/9/16 at 10:30 am, the surveyor observed

1 .Resident #5's wound care was observed by the Director of Nursing on 11/30/16 to ensure dignity was maintained.

2. The Unit Managers completed an audit of residents receiving wound care on 12/2/16 to ensure dignity is upheld during wound care. No issues were identified of this alleged deficient practice.

3. The Director of Nursing in-serviced the Wound Care Nurse on 11/21/16 regarding providing dignity during wound care by dating and initialing the dressing before placement on the resident.

The Director of Nursing/designee will audit wound care on 5 residents a week x 4 weeks, 3 residents a week x 4 weeks, and then 1 resident a week x 4 weeks.

4. The Director of Nursing/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.

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F 241	Continued From page 11 wound care. The wound care nurse washed her hands, applied a pair of non-sterile gloves. She then proceeded to remove the soiled dressing from Resident #5's wound and placed the soiled dressing and the disposable gloves in a plastic bag. She then proceeded to clean the wound. Upon completion of the wound care, she took out her marker and placed the date and her initials on the dressing after it had been applied to the resident. When asked why she initialed and dated the dressing after it was placed on the resident the wound, the wound care nurse said " I normally would have. " On 11/9/16 at 3:55 pm, the surveyor discussed the above wound care observance with the administrator, director of nurses and other administrative staff. Prior to exit on 11/10/16, the above information was discussed with the administrator and the director of nurses.	F 241		12/09/16
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, the facility staff failed to maintain a clean, comfortable, and sanitary environment on 2 of 2 units. For units 1 and 2 of the facility, the facility staff failed to ensure the Resident shower rooms were	F 252	1 .No residents were cited for the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. On 11/09/16 the bars of soap and bottle of shampoo were removed from the shower room. The tub in shower room 2 and the shower chair were cleaned. The shower stalls were washed. The red emergency call cords were replaced by maintenance staff on 12/2/16.	

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F 252	Continued From page 12 clean. On 11/09/16 at approximately 0925, surveyor, along with unit 1 manager observed Resident shower room 1. Surveyor observed one bar soap lying on top of soap dispenser, one bar soap on top of shower disinfectant dispenser, and an open shampoo bottle on top of shower wall. Surveyor asked unit manager if these items should be left out in shower room, and she stated that they should not, and proceeded to remove them. Surveyor, along with unit 1 manager, observed shower room 2 on 11/09/16 at approximately 0930. Surveyor observed bar soap on top of shower wall divider. Shower chair observed to have brownish stain on the seat. Surveyor observed shower room on unit 2 of the facility on 11/09/16 at approximately 0945. Surveyor observed black substance on shower stall walls and on emergency pull cord. Also observed scattered debris in bottom of tub. Concerns of the cleanliness of the shower rooms were discussed with the administrative team during a meeting on 11/09/16 at approximately 1410. No further information was provided prior to exit.	F 252	3. On 11/17/06 the Housekeeping Supervisor in-serviced the housekeeping staff on cleaning the shower rooms. On 11/22/06 the Administrator in-serviced the Housekeeping Supervisor on monitoring the cleanliness of the shower rooms. On 11/28/16 the Director of Nursing in-serviced nursing staff on a clean, comfortable, and sanitary environment in the shower rooms. The Director of Nursing/designee will audit the shower rooms 5 x week x 4 weeks, 3 x week, x 4 weeks, and then 1x week x 4 weeks. 4. The Director of Nursing/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, Admissions/Marketing Director, Dietary Director, HR Director, MDS Coordinator, and Business Office Manager.	12/09/16
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	1. No residents were cited for this alleged deficient practice. 2. All residents who utilize unit 2 shower room have the potential to be affected by this alleged deficient practice.	

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This REQUIREMENT is not met as evidenced by:
Based on obsevation and staff interview the facility staff failed to provide housekeeping and maintenence services in order to ensure a safe, clean environment on 1 of 2 units.

The findings included:

For unit 2 of the facility the staff failed to maintain the door to the shower room in proper working condition.

On 11/09/16 at approximately 0945, the surveyor observed the shower room on unit two of the facility. When exiting the shower room, surveyor observed that the door did not latch appropriately, allowing it to be pushed open without utilizing the keypad lock installed on the door. Surveyor attempted to pull the door to ensure that it latched properly, and the door pulled completely through the door jam, allowing it to swing out into the hallway.

Surveyor discussed the malfunctioning door with the acting maintenance director on 11/09/16 at approximately1250. Acting maintenance director stated that he had been made aware of the door not shutting properly and that he had checked the door. He informed the surveyor that the door was missing a pin at the top, allowing it to move up and down, preventing the door from latching properly.

The concern of the shower door not functioning properly was brought to the attention of the administrative staff on 11/09/16 at approximately 1410.

On 11/09/16 the unit 2 shower room door was fixed to prevent from swinging out into the hallway. On 11/25/16 the unit 2 shower room door was fixed with a new pin.

3. Dn 11/21/16 – 11/25/16 the Administrator conducted an audit of all shower room doors. The unit 1 south shower door was loose. A work order was submitted 11/21/15 and maintenance repaired the door on 11/23/16.

Dn 11/28/16 the Administrator in-serviced the Maintenance Director and Maintenance Assistance regarding proper latching of shower doors and ensuring keypads work.

The Administrator/designee will audit the shower room doors 5 x week x 4 weeks, 3 x week x 4 weeks, and then 1 x week x 4 weeks.

4. The Director of Nursing/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.

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F 253	Continued From page 14 No further information was provided prior to exit	F 253		12/09/16
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. 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, the facility staff failed to maintain a complete an accurate MDS (minimum data set)	F 278	1. Resident #8's MDS was not able to be corrected related to the resident's refusal to be weighed. Resident #3 bowel and bladder assessment was completed by the MDS Coordinator 11/21/16 and is reflective on the most recent MDS assessment dated 7/30/16. 2. A facility wide audit of the MDS for documenting weight and bowel and bladder function was complete by the Director of Nursing on 11/21/16. MDS assessments identified were corrected. A facility wide audit of the year for MDS for documenting weight and bowel and bladder function was complete by the MDS Coordinators on 11/22/16. MDS assessments identified were corrected. 3. On 11/18/16 the Regional Director of Clinical Compliance in-serviced the MDS Coordinators, Director of Nursing, Dietary Manager, Activities Director, Social Services Director, and Administrator regarding maintaining a complete and accurate MDS. The MDS Coordinator/designee will audit for dashes on the MDS by reviewing 5 residents x 4 weeks, 3 residents x 4 weeks, and then 1 resident x 4 weeks.	

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assessment for 2 of 25 Residents, Resident #8 and #3.

The findings included.

1. For Resident #8, the facility staff failed to document the Residents weight on the Residents annual MDS assessment.

The record review revealed that Resident #8 was admitted to the facility 07/15/04. Diagnoses included, but were not limited to, dementia, heart failure, osteoporosis, and constipation.

Section C (cognitive patterns) of the Residents annual MDS assessment with an ARD (assessment reference date) of 03/17/16 included a BIMS (brief interview for mental status) summary score of 5 out of a possible 15.

Section K (swallowing/nutritional status) had a documented height of 60 inches. For the area of weight the facility staff had placed dash marks (-) in the box.

The quarterly assessment prior to this assessment had a documented weight of 89 pounds. The quarterly assessment after this assessment had a documented weight of 90 pounds.

MDS nurse #1 was asked about the missing weight on 11/09/16 at approximately 10:00 a.m. After reviewing the clinical record MDS nurse #1 verbalized to the surveyor that she was unable to locate any documentation stating the Resident had refused to be weighed and she did not know why the weight was not documented.

4. The MDS Coordinator/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.

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The administrative staff were notified of the missing weight during meetings with the survey team on 11/09/16 and 11/10/16.

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

2. The facility failed to accurately code the MDS (Minimum Data Set) for Resident #3.

Resident #3 was readmitted to the facility on 7/27/16 with the following diagnoses of, but not limited to high blood pressure, diabetes, dementia, depression and osteoporosis. The resident was coded on the quarterly MDS with an ARD (Assessment Reference Date) of 7/30/16 as having a BIMS (Brief Interview for Mental Status, an assessment tool) score of 5 out of a possible score of 15. Resident #3 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene.

The surveyor conducted a chart review of Resident #3 ' s clinical record on 11/9/16. The surveyor noted that under Section H: Bladder and Bowel of the MDS with an ARD of 7/30/16, there was a dash placed in the box under H0400: Bowel Continence.

The administrative staff was notified of the above documented findings on 11/9/16 at approximately 3:30 pm.

On 11/10/16 at 4:15 pm, LPN (Licensed Practical Nurse) #1 stated to the surveyor " I didn ' t know about her (residents) bowel movements so I put a dash in it. "

No further information was provided to the

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F 278	Continued From page 17 surveyor prior to the exit conference on 11/10/16.	F 278		12/09/16
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop a CCP (comprehensive care plan) for 1 of 25 Residents, Resident #10. The findings included: For Resident #10 the facility staff failed to develop a CCP within the allotted timeframe after admission.	F 279	1. Resident #10's comprehensive care plan was completed by the MDS Coordinator on 11/11/2016. 2. A facility wide audit of comprehensive care plans was complete by the Director of Nursing on 11/21/16. There were no additional comprehensive care plans identified to not be completed timely. 3. On 11/30/16 the Regional Director of Clinical Compliance in-serviced the MDS Coordinators, Director of Nursing, QA Nurse, Social Services Director, Activities Director, Dietary Director, and Administrator regarding the development of comprehensive care plans. The MD Coordinator/designee will audit for timely completeness of the comprehensive care plan by reviewing 5 residents x 4 weeks, 3 residents x 4 weeks, and then 1 resident x 4 weeks. 4. The MDS Coordinator/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.	

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Resident #10 was admitted to the facility on 08/31/16. Diagnoses included but not limited to atrial fibrillation, coronary artery disease, hypertension, thyroid disorder, arthritis, osteoporosis, hemiplegia, seizure disorder, anxiety and depression.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 09/07/16 coded the Resident as 14 out of 15 in section C, cognitive patterns. This is an admission MDS.

Resident #10's clinical record was reviewed on 11/09/16. It contained an interim care plan dated 09/01/16. The surveyor could not locate a completed CCP.

The surveyor spoke with the MDS coordinator on 11/09/16 at approximately 1350. When asked about the CCP, the MDS coordinator stated "It appears that I overlooked it".

The concern of the missing CCP was discussed with the administrative team during a meeting on 11/09/16 at approximately 1410.

No further information was provided prior to exit.

F 281 SS=E 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS — F 281

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review

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and clinical record review and in the course of a complaint investigation, the facility staff failed to follow professional standards of nursing practice in documenting patient and wound care for 3 of 25 residents. (Resident #3, #25, and #23)

The findings included:

1. The facility staff failed to follow professional standards of nursing practice in documenting the frequency of a medication on the monthly physician orders for Resident #3.

Resident #3 was readmitted to the facility on 7/27/16 with the following diagnoses of, but not limited to high blood pressure, diabetes, dementia, depression and osteoporosis. The resident was coded on the quarterly MDS with an ARD (Assessment Reference Date) of 7/30/16 as having a BIMS (Brief Interview for Mental Status, an assessment tool) score of 5 out of a possible score of 15. Resident #3 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene.

A review of Resident #3 ' s clinical record was performed by the surveyor on 11/9/16. During this review, it was noted by the surveyor that on the monthly physician orders for November, 2016, the following: " Famoidine 20 mg (milligram) Tablet Give 1 Tab (tablet) by mouth every " . The surveyor noted that there was no frequency of the medication documented in which the medication was to be given to the resident.

The administrative staff was notified of the above documented findings on 11/9/16 at approximately 3:30 pm. The surveyor asked for a copy of the standards of nursing in which the facility holds

1. Resident #3's Fomantadine order was clarified on 11/29/16 by a licensed nurse and now appropriately reflects the frequency of the medication.

Resident #25 no longer resides at the facility. LPN #10 is no longer employed by the facility.

Resident #23 no longer resides at the facility.

2. The Director of Nursing, QA nurse, and Unit Managers completed a facility wide on 12/2/16 MAR audit to ensure all orders are complete. Verification of orders identified were corrected.

The Director of Nursing, QA Nurse, and Unit Managers completed a facility wide audit on 12/2/16 of weekly head to toe skin inspections to ensure all residents with impaired skin areas have appropriate treatment orders in place, which are being followed according to physician orders. Appropriate treatment orders not in place were corrected.

The facility currently has no residents with PICC lines.

The Director of Nursing in-serviced licensed nursing staff 11/28/16 on PICC line dressing change.

The Director of Nursing in-serviced licensed nursing staff on 11/28/16 on proper documentation of wound care.

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each nurse accountable for when documenting medication orders.

On 11/10/16 at 8:30 am, the director of nursing (DON) gave the surveyor a copy of a policy titled " Medication Orders and Review " in which the surveyor noted the following under Section " B: Recording Orders " :

" 1. Medication Orders:

When recording orders for medication specify:

a. The type, route, dosage, frequency and strength of the medication ordered ... "

The surveyor asked the DON what was expected of a nurse to document when ordered a medication and the DON stated, " The nurse will document the name of the medication, the route, frequency and the strength of the medication. " The surveyor asked the DON what was the standard that the facility used to hold each nurse accountable for the correct documentation when documenting medications and the DON stated " The nurses are held accountable to what this policy states to document when ordering medications. "

On 11/10/16 at approximately 3 pm, the QA (Quality Assurance) nurse #1 was interviewed by the surveyor. The QA nurse #1 stated that " mandatory staff training was provided back in October on writing physician orders " . The surveyor asked QA nurse #1 if she could provide documentation of this mandatory staff training. QA nurse #1 stated " Let me go to my office and I can get this for you. " QA nurse #1 returned to the conference room with the mandatory training in service sign in record dated for 10/28/16 and a copy of the in service topics that were discussed. In the handouts that were provided to the

The Director of Nursing in-serviced licensed nursing staff on 11/28/16 concerning the completion of physician orders and the 5 Rights of medication administration.

The Director of Nursing/designee will audit physician orders for MAR accuracy 5 residents a week x 4 weeks, 3 residents a week x 4 weeks, and then 1 resident a week x 4 weeks.

The Director of Nursing/designee will audit weekly head to toe skin inspections 5 residents x 4 weeks, 3 residents x 4 weeks, and 1 resident x 4 weeks.

4. The Director of Nursing/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.

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surveyor, it was noted that the following was discussed with the staff regarding physician orders: " Physician ' s Orders Should Contain:
1. Medication
2. Dose
3. Route
4. How often a medication is to be given ... "

No further information was provided to the surveyor prior to the exit conference on 11/10/16.

2. The facility staff failed to follow professional standards of nursing practice in the accuracy of nursing documentation on PICC (Percutaneous Indwelling Central Catheter) line dressing change for Resident #25.

Resident #25 was readmitted to the facility on 12/17/14. The resident had the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes, quadriplegia, anxiety disorder and schizophrenia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/29/16, Resident #25 was coded as having a BIMS (Brief Interview for Mental Status, an assessment tool) score of 0 out of a possible score of 15. The resident was also coded as being totally dependent on 2 or more staff members for personal hygiene and bathing.

A complaint was received in the Office of Licensure and Certification on 8/9/16. The complaint stated " Complainant alleges _____ (Name of Licensed Practical Nurse #10) not providing proper treatment for residents ...the complainant also alleges _____ (Name of LPN #10) falsified documentation. "

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The surveyor reviewed the clinical record of Resident #25 on 11/10/16. The surveyor noted that on the monthly physician orders for August, 2016 the following order: " PICC line dressing change q (every) week ... " The surveyor also reviewed the Treatment Administration Record (TAR) for the month of August, 2016. It was noted that on 8/9/16 and 8/16/16, LPN #10 initialed these dates that indicated that the PICC line dressing change for that date was performed.

The QA (Quality Assurance) nurse #1 was interviewed by the surveyor on 11/10/16 at approximately 2:30 pm in the conference room. The QA nurse #1 was asked by the surveyor if she knew anything about an allegation of " wound care nurse not providing proper treatment " or " falsified documentation " by LPN #10. The QA nurse #1 stated " I know that I did staff education on proper documentation when providing wound care. I can go to my office and get the in service training that I did on this. " QA nurse #1 returned to the conference room with the sign in sheet and in service training that was provided to the staff on 10/28/16.

The corporate nurse was interviewed by the surveyor on 11/10/16 at approximately 2:45 pm in the conference room. The surveyor notified the corporate nurse of the above documented allegations that were called into the office. The corporate nurse stated that there was a complaint called into the corporate hot line on this and " let me go and look into the documentation concerning this matter. " The QA nurse #1 returned to the conference room at approximately 3:30 pm and stated " this is the documentation of the complaint that was called into the corporate

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hot line on this complaint. " The surveyor reviewed the documentation that was received from the facility. The following documentation was noted: " On 8/18/16, it was brought to my attention that resident ____ (name of resident) family member stated her PICC line dressing was not changed. _____ (name of nurse) ...signed out for the dressing change as being done and completed. On 8/16/16 _____ (name of nurse) stated she was sick and another nurse was going to change for her but the dressing was not performed. The PICC line was completed on 8/18/16 by the treatment nurse immediately. "

The surveyor also reviewed the Facility Reported Incident (FRI) that the facility sent into the Office of Licensure and Certification dated September 3, 2016. The following was noted by the surveyor in this report: " Resident #2687 (which is Resident #25) complaint alleges false documentation by _____ (name of LPN). Through interviews with _____ (name of director of nursing) and _____ name of LPN), it was substantiated that ____ (name of LPN) admitted to documenting in error. Complaint alleges the PICC line was changed by ____ (name of LPN) when in fact it was not. _____ (name of LPN) documented that she changed resident #2687 (which is resident #25 in survey sample) PICC line dressing on August 17, 2016, when an inspection of PICC line showed a date of August 9, 2016. This clearly indicated that dressing was not changed. _____ (name of LPN) received disciplinary action for her error in the result of a final written reprimand under the professional standards of practice. "

The director of nursing (DON) at the time of this complaint was not interviewed due to no longer being employed by the facility.

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The administrative staff was notified of the above documented findings on 11/10/16 at approximately 2:50 pm. The current DON was asked by the surveyor for a copy of the standards of practice that they hold staff accountable for when documenting PICC line dressing changes.

At 3:30 pm, the DON returned to the conference room and gave the surveyor a copy of the policy titled " Catheter Insertion and Care " . The DON stated, " This serves as our standard of practice. " Under the section of " General Guidelines " the following was stated:

" 1. Change midline catheter dressing ...every 5-7 days ... "

Under the section of " Documentation " the following was stated:

" 1. the following information should be recorded in the resident ' s medical record:

a. Date and time dressing was changed ...

h. Signature and title of the person recording the data. "

No further information was provided to the surveyor prior to the exit conference on 11/10/16.

This is a COMPLAINT DEFICIENCY.

3. For Resident #23, the facility staff failed to obtain treatment orders for unstageable pressure ulcers when the Resident was admitted to the facility.

This was a closed record review the Resident had expired at the facility.

Resident #23 was added to the sample due to a complaint. The facility had completed an internal investigation prior to the survey and substantiated

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an allegation that the treatment nurse LPN (licensed practical nurse) #10 had failed to obtain treatment orders after the Resident had been admitted to the facility and identified as having unstageable pressure ulcers. The facility re-educated the nurse on professional standards in regards to obtaining appropriate treatments for identified skin issues.

The record review revealed that Resident #23 had been admitted to the facility 08/08/16. Diagnoses included, but were not limited to, unstageable pressure ulcers, malignant neoplasm of bronchus/lung, chronic pain, anxiety disorder, and hypertension.

Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/15/16 was coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. Section G (functional status) had been coded 3/2 for bed mobility indicating the Resident required extensive assistance of two persons to perform this activity. Section M (skin conditions) was coded to indicate the Resident was at risk for developing pressure ulcers and had 6 unstageable deep tissue pressure ulcers.

The Residents CCP (comprehensive care plan) included the problem area "...at risk for skin breakdown R/T (related to) functional status and incontinence. He requires staff assistance with ADLs (activities of daily living) and is incontinent. He was admitted with multiple pressure ulcers..." Approaches included, but were not limited to, "Provide treatments as ordered...Observe and

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report s/s (signs/symptoms) of skin breakdown, pressure reducing mattress to bed and cushion to w/c (wheelchair)."

The Residents "Nursing Admission Assessment" had been completed on 08/09/16 and had been signed by LPN #1. This nursing assessment included the following pressure ulcer of sacral region, unstageable, pressure ulcer of left buttock, unstageable, pressure ulcer of right ankle, unstageable, pressure ulcer of left heel, unstageable, pressure ulcer of left ankle, unstageable, pressure ulcer of other site, unstageable.

The clinical record also included wound assessment reports dated 08/09/16 that identified the following.
Unstageable due to suspected DTI (deep tissue injury) pressure ulcer right bottom of foot. 4.0 cm length X 1.5 cm width.
Unstageable due to suspected DTI pressure ulcer left bottom of heel. 2.5 cm length X 3.5 cm width.
Unstageable due to suspected DTI pressure ulcer left bottom of heel. 3.5 cm length X 2.5 cm width.
Unstageable due to suspected DTI pressure ulcer right medial malleolus. 3 cm length X 1 cm width.
Unstageable due to suspected DTI pressure ulcer left medial malleolus. 2.25 cm length X 1.5 cm width.
Unstageable due to suspected DTI pressure ulcer coccyx. 1 cm length X 2 cm width
Unstageable due to suspected DTI pressure ulcer left buttock. 3 cm length X 1.25 cm width.

These wound assessments were electronically signed by LPN #10 and the previous DNS (director of nursing services).

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Definition of unstageable and DTI from the National Pressure Ulcer Advisory Panel http://www.npuap.org
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.
Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.
There were no treatments ordered when the Resident was admitted to the facility. The following treatments were obtained during the Residents stay at the facility (08/08-09/04/16)
08/09/16-Comfort Care
08/10/16-Betadine to both ankle wounds. Betadine to both heels and buttocks wound everyday.
08/18/16-Discontinue betadine to buttocks heels

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and ankles. Cleanse coccyx wound with normal saline pat dry. Pack with 1/4 strength dakins solution and cover with secondary dressing twice a day.
08/18/16-Skin prep to right and left heel wounds everyday may cover with secondary dressing if needed. Skin prep to right inner and outer ankle wounds everyday may cover with secondary dressing if needed for skin protection.
08/18/16-Skin prep to left inner and outer ankle wounds may cover with secondary dressing for skin protection daily.
08/18/16-Heel protectors to bilateral feet as resident will allow.
08/18/16-Low air loss mattress to aid in prevention of skin breakdown.
08/18/16-Skin prep to wounds to bilateral feet. May cover with secondary dressing for skin protection everyday.
08/18/16-Skin prep to left hip discoloration. May cover with secondary dressing for skin protection everyday.
08/19/16-Skin prep to red area left lower leg. May cover with secondary dressing everyday for skin protection.
08/26/16-Change sacral wound twice a day with 1/4 dakins solution. Crush 1 500 mg flagyl (antibiotic) tablet and sprinkle over wound at dressing change.

The clinical record included documentation by the physician that indicated the Resident had multiple wounds that were unstageable and not preventable secondary to terminal illness and decreased nutrition

On 11/10/16 at approximately 12:45 p.m. the surveyor interviewed LPN #1. LPN #1 was shown her electronic signature on the admitting

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assessment and asked why treatment orders were not obtained when the Resident had been admitted. LPN #1 stated she did not remember signing the assessment and stated this was the first time she had completed an admission and she had only assisted another nurse as this was not her Resident. LPN #1 added that the Resident did not have any open areas on admission the areas were just red.

LPN #10 was not working during the course of the survey. The facility attempted to contact her via phone but was unsuccessful. The DNS that had signed off on the wound assessments was no longer employed at the facility and per the current administrator the investigation was completed by the previous administrator.

The facility staff provided the surveyor with copies of their facility policies/procedures titled "Wound Care Management" and "Physician Orders." The policy title "Wound Care Management" read in part "Each resident receives the care and services necessary to retain or regain optimal skin integrity to the extent possible...Notify the charge nurse, physician and responsible party of the presence of the wound..." The policy titled "Physician Orders" read "Purpose Physician orders are obtained to provide a clear direction in the care of the resident..."

The facility also provided the surveyor with a copy of their standard of practice in regards to wounds from "Lippincott Nursing Procedures seventh edition...Consult with your facility's wound, continence, and ostomy nurse; nutritionist or registered dietician; and physician or occupational therapist as indicated, because pressure ulcer prevention requires a multidisciplinary

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F 309 SS=G	THIS IS A COMPLAINT DEFICIENCY. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation the facility staff failed to provide treatment for the highest practicable level of well being for 8 of 25 Residents, Residents #19, #10, #16, #23, #3, #25, #5 and #14. The findings included: 1. For Resident #19 the facility staff failed to accurately assess and diagnose the	F 309	1. Resident #19 no longer resides at the facility. Resident #10 assessed by licensed nurse 11/10/16 and found to be stable with BM protocol in place with monitoring by licensed nursing staff and found to be stable with no negative outcomes as a result of the alleged deficient practice. Resident #16's physician was notified of failure to follow MD orders for administration of Pyridium and Motrin as ordered. Resident assessed by licensed nurse on 12/2/16 and found to be stable with no negative outcomes as a result of the alleged deficient practice.	

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communicable disease, scabies, resulting in a delay of treatment.

Resident #19 was admitted to the facility on 09/06/12 and readmitted on 10/14/16. Diagnoses included but not limited to Alzheimer's disease, bipolar disorder, schizophrenia, insomnia, constipation and colon cancer.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/21/16 coded the Resident as 2 out of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident's CCP (comprehensive care plan) reviewed at this time.

Resident #19's clinical record was reviewed on 11/09/16. It contained the following nurse's notes which read in part:

"9/3/2016 4:00AM On 9-2-16 at 11:00pm Resident came to nurses med cart crying. Resident c/o (complained of) itching all over. States 'it wont stop itching and its driving me crazy'. States 'It feels like something crawling under my skin'. Res (sic) has a few small raised like areas noted on her left back. No rash noted on rest of Residents body. Called on call Dr ... (name omitted). New order noted for Vistaril 25mg every 6 hours prn (as needed). RP (responsible party) notified."

"9/10/2016 6:58 AM Resident continues to complain of severe itching and is requesting to be seen by MD. Given Vistaril per prn order. Res (sic) states 'It helps but doesn't make it stop'."

"9/16/2016 6:31 AM Medication follow-up- (VISTARIL 25 MG CAPSULE 1 cap by mouth ev) Medication was effective."

Resident #23 is no longer a resident of the facility.

Resident #3 assessed by licensed nurse on 11/10/16 and found to be stable with BM protocol in place with no negative outcome.

Resident #25 is no longer a resident of the facility. LPN #10 is no longer employed at the facility.

Resident #14 assessed by licensed nurse on 11/10/16 and found to be in stable condition with no negative outcomes as a result of receiving inaccurate Calcium supplement. The physician was notified on 11/10/16 by licensed nurse.

Resident #5 was assessed by licensed nurse on 11/10/16 and found to be stable with no negative outcomes as a result of Multi-vitamin not being administered according to the physicians order. The physician was notified by licensed nurse 11/10/16 and clarification order received.

2. A facility wide skin sweep was completed on 12/2/16 by the Unit Managers, Director of Nursing, and the QA Nurse. No other residents were found to be affected by the alleged deficient practice.

A facility wide Bowel and Bladder audit was completed on 12/2/16 by the Director of Nursing, QA nurse, and Unit Managers. Identified residents were placed on the Bowel and Bladder Protocol.

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"9/18/2106 7:53 AM Resident continues to c/o of itching all over. Resident has several small red spots on right thigh and back of neck. Given Vistaril per prn order. MD made aware."

"9/19/2016 5:35 PM NO (new order): ....CHANGE VISTARIL TO 50MG PO (by mouth) Q6HRS (every 6 hours) PRN."

"9/24/2016 9:45 PM Continues on Cipro for UTI. No adverse reactions noted. Skin warm and dry. Continues to c/o itching at times. No acute distress noted. Call light and PO fluids within reach."

"10/6/2016 9:53 PM Medication Follow-up - (VISTARIL 50 MG CAPSULE BY MOUTH EVERY 6) Medication was effective."

"10/8/2016 9:33 PM Medication Follow-up - (VISTARIL 50 MG CAPSULE BY MOUTH EVERY 6) Medication was effective."

"10/13/2016 2:50 AM ....visteral (sic) for complaint of nervousness. Res. slept til this time, complaint of itching. had visteral (sic) earlier at 1am....."

"10/13/2016 6:26 AM 4am Res. was up in wheelchair complaint of itching and sharp pain in upper Lt. chest....."

"10/15/2016 NEW ORDER: TRIAMCINIOLONE 0.1% APPLY TO AFFECTED THIGH BID X 7 DAYS. DERMATOLOGY EVAL....."

"10/18/2016 12:12 AM ....Resident had

A facility wide weekly skin inspections audit was completed on 12/2/16 by the Director of Nursing, QA nurse, and Unit Managers to ensure all current residents with skin impairments have an appropriate treatment order in place. No other residents were found to be affected.

A facility wide MAR audit was completed on 12/2/2016 by the Director of Nursing, QA nurse, and Unit Manager to ensure each current physician order is completed with medication, dosage, route, and frequency. No other residents were identified to be affected through the audit.

Currently there are no residents in the facility with a PICC line.

3. The Director of Nursing in-serviced licensed nursing staff 11/28/16 on entering physician orders to include the 5 Rights of medication administration.

The Director of Nursing in-serviced licensed nursing staff 11/28/16 on changing PICC line dressing.

The Director of Nursing in-serviced licensed nursing staff 11/28/16 on the bowel protocol.

On 12/2/16 the Medical Director discontinued the Bowel and Bladder Protocol.

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complained with itching and this nurse administered Vistril (sic) @ approx. 8 pm....."

"10/19/2016 2:04 AM Resident complaining of itching and Resident was saw by staff her stratching (sic) herself. This nurse administered vistril (sic) as ordered....."

"10/19/2016 7:11 AM VISTRARIL 50 MG CAPSULE BY MOUTH EVERY 6.... complaints of itching."

"10/20/2016 10:37 PM Medication Follow-up - (VISTARIL 50 MG CAPSULE BY MOUTH EVERY 6) Medication was effective."

"10/28/2016 12:20 AM Medication Follow-up - (VISTARIL 50 MG CAPSULE BY MOUTH EVERY 6) Medication was effective."

"10/28/2016 9:37 PM New order for Permethrin 5% external cream apply to skin from neck to soles of feet. and wash off after 8 hours. Daughter notified of this order."

"10/29/2016 8:14 AM At 2:00am Given shower and premethrin (sic) cream applied to entire body per orders. Reported to oncoming shift."

Resident #19's clinical record contained the following physician's progress notes which read in part:

"9/21/16 Cc (chief complaint): Acute UTI (urinary tract infection). Pt stated she dropped her spoon, was sent to ER for S/S (signs/symptoms) of 'stroke'. Yesterday she was sent back to facility s (without) any new orders." Resident's

The Director of Nursing in-serviced licensed nursing staff 11/28/16 on wound care including identification, staging, documentation, and treatment and skin care.

LPN #10 is no longer employed at the facility.

The Director of Nursing/designee will audit the bowel movement protocol for 5 residents x 4 week, 3 residents x 4 weeks, and then 1 resident x 4 weeks.

The Director of Nursing/designee will audit entering of physician orders on the MAR 5 residents x 4 weeks, 3 residents x 4 weeks, and then 1 resident x 4 weeks.

The Director of Nursing/designee will audit skin sweeps of 5 residents x 4 weeks, 3 residents x 4 weeks, and then 1 resident x 4 weeks.

The Director of Nursing/designee will audit weekly skin inspections of 5 residents x 4 weeks, 3 residents x 4 weeks, and then 1 resident x 4 weeks.

The Director of Nursing/designee will audit PICC line changing, as needed, of 5 residents x 4 weeks, 3 residents x 4 weeks, and then 1 resident x 4 weeks.

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complaints of itching were not addressed.

"9/29/16 Cc: Recert". Resident's complaints of itching were not addressed.

"10/6/16 Cc: Readmitt to ....(name omitted) s/p (status post) fall...."- Complaints of itching not addressed.

10/12/16 Cc: Burn ....No sig (sic) rash noted scant petechiae which appear age related".

"10/15/16 Cc: Pt c (with) rash B (bilaterally) .... (writing illegible). Has had x > (greater than) 30 d, had ....(writing illegible) has grandchild c rect (recent) Dx (diagnosis) of scabies.
-scant 0 erythematic rash trunk, LE (lowere extrimities) B (bilaterlly), 0 raised, flat, no .... (writing illegible). Assessment: Rash-does not appear to be scabies 0 classic ..... (illegible) Re (Red raised rash c tunneling) Rec. derm eval."

"10/17/16 Cc: fu (follow up) rash. Flat light rash B LE trunk 0 red, 0 rash 0 raised 0 ... (illegible). Assessment: Rash- No...(illegible) c (with) scabies 0 red, 0 raised, 0 tunnelling. Although I may not be correct. Therefore given Hx (history) of family c scabies, will ask for derm. eval + scraping to see what is cause. If it is scabies certainly not classic presentation."

"10/28/16 Cc: Pt c derm evl today, scraping + scabies"

Resident #19's clinical record contained a "Report of Consultation" dated 10/28/16 which read in part "Chief complaint: 1) Itching all over-2 months. History of Present Illness: Patient presents today for evaluaton of a severely pruritic

The Director of Nursing/designee will audit wound care on 5 residents x 4 weeks, 3 residents x 4 weeks, and then 1 resident x 4 weeks.

4. The Director of Nursing/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.

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rash that has been occurring on her wrists and ankles and upper back for the past 2 months. Multiple family members have been diagnosed and treated for scabies. No prior treatment for scabies per patient. No other skin complaints. Patient lives at ....(name omitted). Physical exam: Burrows on wrists bilaterally. Few excoriations on the upper back. Assessment: Scabies".

According to the Virginia Department of Health epidemiology fact sheet, scabies is a "disease of the skin caused by a mite. Scabies mites burrow into the skin, producing pimple-like irritations or burrows". Symptom of scabies include "intense itching, especially at night" with areas affected to include "wrists, elbows, armpits, waist, thighs....".

Surveyor spoke with the administrative team on 11/10/16 at approximately 1515 regarding Resident #19. Surveyor asked administrative team how soon after a request is made by a Resident to see the physician should the Resident be seen. The interim DON (director of nursing) stated when a Resident requests to be seen by the physician, they should be seen with 24 hours or as soon as is reasonably possible if request is made on weekend.

Surveyor requested and was provided with a copy of facility policy entitled "Residents Right" which read as follows:

"A. Residents Rights:

It is our belief that you as a Resident have the right to expect certain standards of care and considerations while at our facility. You have the right to:

1. Expect reasonable responses to requests to services within our

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capacity, our stated mission and applicable law and regulation."

Surveyor spoke with the FNP (family nurse practitioner) on 11/1016 at approximately 1730 regarding Resident #19. FNP stated the he initially saw Resident due to complaints of itching and rash on trunk. FNP stated that Resident had some small petechiae on both thighs. FNP stated that CNA (certified nurse's aide) told him that the rash became more prominent when Resident showered. FNP stated that Resident was initially treated with Vistaril for the itching. After 1 week, Resident had a little more rash. FNP stated that over the next few weeks, the Resident's rash appeared no better, but no worse. FNP stated some success with Vistaril and triamcinolone cream. FNP stated that Resident had grandchild that had tested positive for scabies. FNP stated that Resident's rash did not look like scabies and that the facility medical director agreed, but sent for dermatology consult to be sure. Surveyor asked FNP why Resident had not been seen by dermatology sooner, and FNP stated that since Resident has dementia, he did not want to send her out and disrupt her regular routine. FNP stated that at times the rash seemed better with treatment.

The concern of the delay in treatment was discussed with the administrative staff during a meeting on 11/10/16 at approximately 1515.

Prior to exit conference, the interim DON provided the surveyor with copies of physician's progress notes which were not included in Resident's clinical record at time of surveyor review. These progress notes read in part:

"9/12/16 Pt c rash R anterior thighs, tx

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(treatment) with Vistaril for itching Plan: Observe, fu (follow up) 1 week".

"9/19/16 Pt c fu rash....(writing illegible) Assessment: Rash...(illegible) Plan: ...(illegible) ? need for scraping."

No further information was provided prior to exit.

2. For Resident #10 the facility staff failed to follow facility established bowel protocol.

Resident #10 was admitted to the facility on 08/31/16. Diagnoses included but not limited to atrial fibrillation, coronary artery disease, hypertension, thyroid disorder, arthritis, osteoporosis, hemiplegia, seizure disorder, anxiety and depression.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 09/07/16 coded the Resident as 14 out of 15 in section C, cognitive patterns. This is an admission MDS.

Resident #10's clinical record was reviewed on 11/09/16. It contained a signed POS (physician's order summary) dated 10/31/16 which read in part "Miralax Powder-Give 17gm by mouth daily as needed".

Resident #10's MAR's (medication administration record) for the months of September and October 2016 were reviewed. The MAR for September contained an entry which read in part "Miralax Powder, Give 17gm by mouth daily". This entry had been signed as having been administered as ordered. The MAR for October contained an entry which read in part "Miralax Powder, Give 17gm by

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mouth daily. Discontinue date 10/17/16". This entry had been signed as having been administered as ordered. The MAR for October also contained an entry which read in part "Miralax Powder-Give 17gm by mouth daily as needed. Order date: 10/17/16. This entry had not been signed as having been administered.

Resident #10's electronic record contained "BM (bowel movement) Record Roster" for the months of September and October 2016. For the month of September, the BM roster indicated a period of 6 days (09/02-09/07/16) and a period of 5 days (09/20-09/25/16) with no recorded BM for Resident #10. For the month of October, the BM roster indicated a period of 5 days (10/25-10/30/16) and a period of 4 days (10/30-11/04/16) with no recorded BM.

The Resident's clinical record also contained copy of the facility "Bowel Protocol" which read in part "No BM x 2 days-Please administer 30ml Milk of Magnesia q.h.s. x 1 at bedtime. No BM x 3 days- Please administer Dulcolax suppository x 1 at bedtime. No BM x 4 days-Please administer Fleets enema x 1 at bedtime. Bowel movement documentation will be reviewed by the 2-11 charge nurses for each unit and medication administered per review of the BM record for each Resident. All laxatives will require documentation on MAR fro (sic) that Resident."

The surveyor could not locate any supporting documentation to indicate that the bowel protocol had been instituted for Resident #7.

The concern of not following the bowel protocol was discussed with the administrative team during a meeting on 11/09/16 at approximately

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1410.

No further information was provided prior to exit.
3. For Resident #16, the facility staff failed to administer the medications pyridium and motrin as ordered by the physician.

The record review revealed that Resident #16 had been admitted to the facility 01/23/13. Diagnoses included, but were not limited to, end stage renal disease, diabetes, heart failure, anxiety, insomnia, and hypothyroidism.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/13/16 included a BIMS (brief interview for mental status) score of 14 out of a possible 15 points.

Resident #16's clinical record included the following physician ' s telephone orders.
1. 10/26/16 for pyridium 100 mg 1 PO (by mouth) q (every) 8 hours X 72 hours for dysuria. For a total of 9 doses.
2. 10/28/16 for motrin 500 mg 1 TID (three times a day) X 2 days for tooth extraction. For a total of 6 doses.

A review of Resident #16's eMAR (electronic medication administration records) indicated that only 6 doses of the pyridium and 4 doses of the motrin had been administered.

On 11/09/16 at approximately 8:25 a.m. the surveyor and the QA (quality assurance nurse) reviewed the Residents pyridium and motrin orders. After reviewing the orders and eMAR the QA nurse verbalized to the surveyor that the

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Resident did not receive enough doses of either medication.

After this issue was identified by the surveyor the Resident was out for dialysis and was unable to be interviewed.

The administrative staff were notified of the above in a meeting with the survey team on 11/10/16 at approximately 3:10 p.m.

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

4. For Resident #23, the facility staff failed to obtain treatment orders for unstageable pressure ulcers when the Resident was admitted to the facility.

This was a closed record review the Resident had expired at the facility.

Resident #23 was added to the sample due to a complaint. The facility had completed an internal investigation prior to the survey and substantiated an allegation that the treatment nurse LPN (licensed practical nurse) #10 had failed to obtain treatment orders after the Resident had been admitted to the facility and identified as having unstageable pressure ulcers. The facility re-educated the nurse on professional standards in regards to obtaining appropriate treatments for identified skin issues.

The record review revealed that Resident #23 had been admitted to the facility 08/08/16. Diagnoses included, but were not limited to,

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unstageable pressure ulcers, malignant neoplasm of bronchus/lung, chronic pain, anxiety disorder, and hypertension.

Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/15/16 was coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. Section G (functional status) had been coded 3/2 for bed mobility indicating the Resident required extensive assistance of two persons to perform this activity. Section M (skin conditions) was coded to indicate the Resident was at risk for developing pressure ulcers and had 6 unstageable deep tissue pressure ulcers.

The Residents CCP (comprehensive care plan) included the problem area "...at risk for skin breakdown R/T (related to) functional status and incontinence. He requires staff assistance with ADLs (activities of daily living) and is incontinent. He was admitted with multiple pressure ulcers..." Approaches included, but were not limited to, "Provide treatments as ordered...Observe and report s/s (signs/symptoms) of skin breakdown, pressure reducing mattress to bed and cushion to w/c (wheelchair)."

The Residents "Nursing Admission Assessment" had been completed on 08/09/16 and had been signed by LPN #1. This nursing assessment included the following-pressure ulcer of sacral region, unstageable, pressure ulcer of left buttock, unstageable, pressure ulcer of right ankle, unstageable, pressure ulcer of left heel, unstageable, pressure ulcer of left ankle,

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unstageable, pressure ulcer of other site, unstageable.

The clinical record also included wound assessment reports dated 08/09/16 that identified the following.
Unstageable due to suspected DTI (deep tissue injury) pressure ulcer right bottom of foot. 4.0 cm length X 1.5 cm width.
Unstageable due to suspected DTI pressure ulcer left bottom of heel. 2.5 cm length X 3.5 cm width.
Unstageable due to suspected DTI pressure ulcer left bottom of heel. 3.5 cm length X 2.5 cm width.
Unstageable due to suspected DTI pressure ulcer right medial malleolus. 3 cm length X 1 cm width.
Unstageable due to suspected DTI pressure ulcer left medial malleolus. 2.25 cm length X 1.5 cm width.
Unstageable due to suspected DTI pressure ulcer coccyx. 1 cm length X 2 cm width
Unstageable due to suspected deep tissue injury pressure ulcer left buttock. 3 cm length X 1.25 cm width.

These wound assessments were electronically signed by LPN #10 and the previous DNS (director of nursing services).

Definition of unstageable and DTI from the National Pressure Ulcer Advisory Panel http://www.npuap.org
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.
Deep Tissue Pressure Injury: Persistent

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non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly-pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.
There were no treatments ordered when the Resident was admitted to the facility. The following treatments were obtained during the Residents stay at the facility (08/08-09/04/16)
08/09/16-Comfort Care
08/10/16-Betadine to both ankle wounds. Betadine to both heels and buttocks wound everyday.
08/18/16-Discontinue betadine to buttocks heels and ankles. Cleanse coccyx wound with normal saline pat dry. Pack with 1/4 strength dakins solution and cover with secondary dressing twice a day.
08/18/16-Skin prep to right and left heel wounds everyday may cover with secondary dressing if needed. Skin prep to right inner and outer ankle wounds everyday may cover with secondary dressing if needed for skin protection.
08/18/16-Skin prep to left inner and outer ankle wounds may cover with secondary dressing for

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skin protection daily.
08/18/16-Heel protectors to bilateral feet as resident will allow.
08/18/16-Low air loss mattress to aid in prevention of skin breakdown.
08/18/16-Skin prep to wounds to bilateral feet. May cover with secondary dressing for skin protection everyday.
08/18/16-Skin prep to left hip discoloration. May cover with secondary dressing for skin protection everyday.
08/19/16-Skin prep to red area left lower leg. May cover with secondary dressing everyday for skin protection.
08/26/16-Change sacral wound twice a day with 1/4 dakins solution. Crush 1 500 mg flagyl (antibiotic) tablet and sprinkle over wound at dressing change.

The clinical record included documentation by the physician that indicated the Resident had multiple wounds that were unstageable and not preventable secondary to terminal illness and decreased nutrition.

On 11/10/16 at approximately 12:45 p.m. the surveyor interviewed LPN #1. LPN #1 was shown her electronic signature on the admitting assessment and asked why treatment orders were not obtained when the Resident had been admitted. LPN #1 stated she did not remember signing the assessment and stated this was the first time she had completed an admission and she had only assisted another nurse as this was not her Resident. LPN #1 added that the Resident had no open areas on admission that the areas were just red.

LPN #10 was not working during the course of

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the survey. The facility attempted to contact her via phone but was unsuccessful. The DNS that had signed off on the wound assessments was no longer employed at the facility and per the facility the investigation was completed by the previous administrator.

The facility staff provided the surveyor with copies of their facility policies/procedures titled "Wound Care Management" and "Physician Orders." The policy title "Wound Care Management" read in part "Each resident receives the care and services necessary to retain or regain optimal skin integrity to the extent possible...Notify the charge nurse, physician and responsible party of the presence of the wound..." The policy titled "Physician Orders" read "Purpose Physician orders are obtained to provide a clear direction in the care of the resident..."

The facility also provided the surveyor with a copy of their standard of practice in regards to wounds from "LIPPINCOTT Nursing Procedures (seventh edition)." This standard of practice included the following "...Consult with your facility's wound, continence, and ostomy nurse; nutritionist or registered dietician; and physician or occupational therapist as indicated, because pressure ulcer prevention requires a multidisciplinary approach...If left untreated, pressure ulcers may produce ischemia and local infection..."

On 11/10/16 at approximately 3:10 p.m. the administrative staff were made aware of the concerns regarding the absence of treatment orders for Resident # 23.

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

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conference.

THIS IS A COMPLAINT DEFICIENCY.

5. The facility staff failed to follow the physician ordered bowel protocol for Resident #3.

Resident #3 was readmitted to the facility on 7/27/16 with the following diagnoses of, but not limited to high blood pressure, diabetes, dementia, depression and osteoporosis. The resident was coded on the quarterly MDS with an ARD (Assessment Reference Date) of 7/30/16 as having a BIMS (Brief Interview for Mental Status, an assessment tool) score of 5 out of a possible score of 15. Resident #3 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene.

The surveyor conducted a chart review of Resident #3 ' s clinical record on 11/9/16. It was noted by the surveyor that on the Bowel report or Resident #1 that there was no bowel movements documented in the clinical record for the following dates: 10/2/16 through 10/5/16, 10/7/16 through 10/9/16 and 11/4/16 through 11/7/16. The surveyor also reviewed the standing orders for the bowel protocol. The bowel protocol stated the following in which to be followed by the nursing staff:

· " No BM (bowel movement) X (times) 2 days-Please administer 30 ml (milliliters) Milk of Magnesia qhs (every night) X 1 at bedtime.
· No BM X 3 days-Please administer Dulcoloax suppository X1 at bedtime.
· No BM X 4 days-Please administer Fleets enema X1 at bedtime.
· Bowel movement documentation will be reviewed by the 3-11 charge nurses for each unit

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and medication administrated per review of the BM record for each resident.

· All laxatives will require documentation on MAR (Medication Administration Record) for that resident. "

The resident ' s Mar for the above documented dates were reviewed as well as the nurses ' notes for interventions of the bowel protocol given to the resident as needed. The surveyor found no documentation of the bowel protocol being followed for the above documented dates.

The administrative staff was notified of the above documented findings on 11/9/16 at approximately 3 pm by the surveyor.

No further information was provided to the surveyor prior to the exit conference on 11/10/16.

6. The facility failed to change a PICC (Percutaneous Indwelling Central Catheter) line dressing change as ordered by the physician for Resident #25.

Resident #25 was readmitted to the facility on 12/17/14. The resident had the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes, quadriplegia, anxiety disorder and schizophrenia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/29/16, Resident #25 was coded as having a BIMS (Brief Interview for Mental Status, an assessment tool) score of 0 out of a possible score of 15. The resident was also coded as being totally dependent on 2 or more staff members for personal hygiene and bathing. This resident was added to the survey sample due to the investigation of a complaint in which the resident

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was found to be in that the Office of Licensure and Certification obtained on 8/9/16 by an anonymous staff member.

The surveyor reviewed the clinical record of Resident #25 on 11/10/16. The surveyor noted that on the monthly physician orders for August, 2016 the following order: " PICC line dressing change q (every) week ... " The surveyor also reviewed the Treatment Administration Record (TAR) for the month of August, 2016. It was noted that on 8/9/16 and 8/16/16, LPN #10 initialed these dates that indicated the PICC line dressing change for that date was performed.

During investigation of this complaint, the QA (Quality Assurance) nurse #1 was interviewed on 11/10/16 at approximately 2:30 pm by the surveyor in the conference room. The QA nurse #1 was asked by the surveyor if she knew anything about an allegation of " wound care nurse not providing proper treatment " LPN #10. The QA nurse #1 stated " I know that I did staff education on proper documentation when providing wound care. I can go to my office and get the in service training that I did on this. " QA nurse #1 returned to the conference room with the sign in sheet and in service training that was provided to the staff on 10/28/16.

The corporate nurse was interviewed by the surveyor on 11/10/16 at approximately 2:45 pm in the conference room. The surveyor notified the corporate nurse of the above documented allegation that was called into our office. The corporate nurse stated that there was a complaint called into the corporate hot line on this and stated " let me go and look into the

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documentation concerning this matter. " The QA nurse #1 returned to the conference room at approximately 3:30 pm and stated " this is the documentation of the complaint that was called into the corporate hot line. " The surveyor reviewed the documentation that was received from the facility. The following documentation was noted: " On 8/18/16, it was brought to my attention that resident ____ (name of resident) family member stated her PICC line dressing was not changed. _____ (name of nurse) ...signed out for the dressing change as being done and completed. On 8/16/16 _____ (name of nurse) stated she was sick and another nurse was going to change for her but the dressing was not performed. The PICC line was completed on 8/18/16 by the treatment nurse immediately. "

The administrative staff was notified of the above documented findings on 11/10/16 at approximately 2:50 pm.

No further information was provided to the surveyor prior to the exit conference on 11/10/16.

COMPLAINT DEFICIENCY
7. During medication pass observation the facility staff failed to follow physician orders for administration of medications for Resident #14. Resident #14 was admitted to the facility on 5/23/15 and readmitted on 8/8/16. His diagnoses include but are not limited to high blood pressure, hypothyroidism, cerebral infarction, sleep disorder and depression

Resident #14's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 10/4/16 assessed him to understand and could be understood. He was assessed to

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have as cognitive status of 12 out of 15. His assessment revealed in section G, he needed assistance with daily activities of living.

On 11/9/16 starting at 7:51a.m., the surveyor observed LPN #1 administer Resident #14 ' s morning medications. During the medication pass the LPN#1 administered Calcium 500 mg one by mouth. The surveyor observed the bottle that the medication came from; it read calcium 500 mg.

During physician order and medication administration review the surveyor noted that the calcium order read as follows: Calcium 500 mg +vitamin D 200, take one twice daily. LPN #1 administered Calcium 500 mg. The surveyor returned to the medication cart and asked LPN #1 to look at the Calcium bottle and the order. She stated " I thought it had vitamin D2 in it. "

On 11/9/16 at 3:55 pm, the surveyor discussed the above medication pass observance with the administrator, director of nurses and other administrative staff.

Prior to exit, no further information was provided by the facility staff related to the medication error.

8. For Resident #5 the facility staff failed to follow physician orders for administration of her multiple vitamin.

Resident #5 was admitted to the facility 3/17/06 and readmitted on 8/29/16 with diagnoses that included but not limited to high blood pressure, thyroid disorder, heart failure, esophageal reflux disorder, depression, and manic depression.

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A review of Resident #5's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 8/10/16, the facility staff assessed the resident to understand and usually to be understood. She was assessed to have a cognitive summary score of 03.

Review of Resident #5 ' s physician ' s orders revealed she had an order for a multiple vitamin with minerals. The vitamin was ordered on 9/28/16 as follows: Multiple Vitamin W-Minerals TB -give 1 tablet by mouth daily x 45 days. The vitamin was started on 9/28/16, the discontinue date was 10/28/16. The medication was not given for the entire 45 days.

On 11/8/16 at 3:35 pm, the quality assurance nurse (QA) nurse was asked why the vitamin had not been given for a full 45 days as ordered. Looking at the chart she said " I don ' t see a discontinue order, I will check why it wasn ' t given. She then told the surveyor " someone has stopped the vitamin without an order. "

On 11/9/16 at 3:55 pm, the surveyor discussed the above medication error with the administrator, director of nurses and other administrative staff.

Prior to exit, no further information was provided by the facility staff related to the medication error.

F 325 SS=D 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE

F 325

Based on a resident's comprehensive assessment, the facility must ensure that a resident -
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels,

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F 325	Continued From page 52 unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed to provide nutritional supplements as ordered by the physician for 1 of 25 residents. (Resident #15) The findings included: Resident #15 was admitted to the facility on 7/4/16 with the following diagnoses of, but not limited to high blood pressure, diabetes, arthritis, chronic obstructive pulmonary disease, chronic pain and muscle weakness. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/11/16, Resident #15 was coded as having a BIMS (Brief Interview for Mental Status, an assessment tool) score was 15 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 1 staff member for personal hygiene and bathing. On 11/9/16 at 8:30 am, LPN (Licensed Practical Nurse) #1 asked to speak to the surveyor. LPN #1 stated that the family of _____ (name of resident #15) has to buy the Ensure for the resident to have. The son told me that the nursing home told him that they could not provide it for his mother and he was upset because this is	F 325	12/09/16 1. For resident #15 the facility provides the nutritional supplement as ordered by the physician. The Administrator contacted the resident #15's son on 11/28/16. Reimbursement of the supplement was offered to the son. 2. The Interim Director of Nursing completed a facility wide audit on 11/16/16 of physician ordered supplements. The Dietary Director completed a facility wide audit on 11/18/16 of physician ordered supplements. The facility provides all supplements ordered by the physician. No other residents were identified to be affected by the alleged deficient practice. On 11/15/16 the Central Supply staff inventoried the stock of Ensure. On 11/28/16 staff were in-serviced the facility is responsible for paying for and providing physician ordered supplements. 3. The Administrator in-serviced the Central Supply staff member on 11/22/16 regarding appropriate stock of Ensure. The Dietary Director/designee will audit that residents receive nutritional supplements as ordered 5 residents x 4 weeks, 3 residents x 4 weeks, and then 1 resident x 4 weeks. The Central Supply staff member/designee will audit the Ensure for adequate availability of supplements 5 x a week x 4 weeks, 3 x week x 4 weeks, and then 1 x week x 4 weeks.	

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very expensive for him to buy. "

LPN #2 was interviewed by the surveyor at 9:20 am. The surveyor asked LPN #2 if she had ever card for Resident #15 I PN #2 stated " Yes, I have. " The surveyor asked LPN #2 who supplied the Ensure for the resident to have. LPN #2 stated " I remember that the resident got Ensure twice a day for 3 days then the resident received Mighty Shakes. The resident didn ' t like them and she requested that she have Ensure. I know the son brings in the Ensure for the resident and places it in the refrigerator for us to give to her. But I don ' t know if he was told by the facility to do this. "

On 11/10/16 at 8:45 am, the resident was interviewed by the surveyor and the resident stated " My family is having to but the Ensure for me to drink. The nursing home doesn ' t provide it for me and it is expensive for my family to buy. They keep it in the refrigerator for me and all I do is to ask for it and they will bring it to me. "

A review of Resident #15 ' s clinical record was performed by the surveyor on 11/10/16. The surveyor noted a physician order for " Ensure twice daily per resident request " dated for 10/27/16. The surveyor reviewed the MAR (Medication Administration Record) for November, 2016. On this MAR, it was noted that " Ensure twice daily per resident request " with the times of " 12:00 pm and 5:00 pm " listed for this to be administrated to the resident. From 11/1/16 through 11/9/16 a nurse has initialed that the Ensure was administrated to the resident at 12:00 pm and 5:00 pm for each day.

The director of nursing and administrator that

4. The Dietary Director/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.

4. The Central Supply staff member /designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.

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were in the facility at the time that the Ensure had been ordered are no longer employed at the facility. The corporate nurse was interviewed on 11/10/16 at 10:15 am by the surveyor. The surveyor asked the corporate nurse if Ensure was ordered for a resident who is responsible for paying or providing that for the resident. The corporate nurse stated " The facility is responsible to provide the Ensure to the resident if the physician ordered for the resident to have it. " The surveyor asked if the facility was paying or providing Ensure for Resident #15 because Ensure was ordered on 10/27/16 by the physician. The corporate nurse stated "' The facility should provide this for the resident. " The surveyor notified the corporate nurse that during a resident interview the resident reported that the Ensure was being bought by her family and put in the refrigerator for her to have. The surveyor also notified the corporate nurse that during a staff interview the staff member stated that the family was upset because they had to buy Ensure for his mother to have. The corporate nurse stated " I am unaware that the family was buying the Ensure for the resident. I will have to look into this. "

The dietary manager was interviewed by the surveyor on 11/10/16 at 10:30 am in the conference room. The dietary manager was asked by the surveyor if the facility had Ensure to give to residents when it had been ordered by the physician for the resident to have. The dietary manager stated " Yes ". The dietary manage asked the surveyor if there had been a problem. The dietary manager was notified of the above documented findings regarding Ensure being bought by Resident #15 ' s family for the resident to have. The dietary manager stated " Let me go

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back to my office and see what we have down for this resident as far as any supplements that have been ordered. The dietary manager returned to the conference room and stated, " I have her down on the list to receive Ensure twice a day. " The surveyor asked who was responsible for paying or providing the Ensure to the resident. The dietary manager stated " If the physician has ordered for the resident to have it then the facility provides it for the resident. "

The administrative staff was notified of the above documented findings on 11/10/16 at approximately 3:15 pm.

No further information was provided to the surveyor prior to the exit conference on 11/10/16.

COMPLAINT DEFICIENCY

F 431 SS=D 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS — F 431

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

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In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, the facility staff failed to label a multi-use vial of flu vaccine in the medication room on Unit 2 of the facility.

The findings include:

During the initial tour of the facility on 11/8/16 at 11:35 am, the surveyor went into the medication room on Unit 2. In this medication room, in the refrigerator, the surveyor observed a multi-use vial Flu vaccine that was open but was not labeled with an open date. LPN (Licensed Practical Nurse) #10 was with the surveyor when this observation was made. LPN #10 stated " We are to write the date we open the vial on it. "

On 11/8/16 at 2 pm, the director of nursing (DON) was notified of the above documented findings.

1. No residents were cited for this alleged deficient practice. The unlabeled multi-use vial was disposed by the licensed nurse on 11/8/16.

2. On 11/15/16 the Interim Director of Nursing conducted an audit of medication rooms and refrigerators for multi-use vials. One multi-use vial was identified and disposed of.

3. The Director of Nursing in-serviced licensed nursing staff on 11/28/16 regarding the labeling of multi-use vials.

The Director of Nursing/designee will audit the medication rooms and refrigerators 5 x per week x 4 weeks, 3 x per week x 4 weeks, and then 1 x per week x 4 weeks.

4. The Director of Nursing/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.

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The surveyor asked the DON for a copy of the policy concerning labeling multi-use vials when they were opened.

At 2:30 pm, the DON returned to the surveyor with a copy of the policy titled " ...Vials and Ampules of Injectable Medications " . Under the section " Procedures," the policy states the following: " Opening a vial triggers a shortened expiration date that is unique for that product. The date opened and this triggered expiration date are both important to be recorded on multidose vials ...At a minimum, the date opened must be recorded ... "

On 11/9/10 at approximately 3 pm, the administrative staff was notified of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 11/10/16.

F 441 SS=D 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS F 441

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective

1. Resident #19 no longer resides in the facility.

2. Residents who receive ice on Unit 1 have the potential to be affected by the alleged deficient practice.

3. A facility wide skin sweep was complete 12/2/16 by the Director of Nursing, QA nurse, and Unit Managers to assess for dermatology issues. No other residents were found to be affected.

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actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) 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.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to maintain an effective infection control program on 1 of 2 units (unit 1) and for 1 of 25 Residents, Resident #19.

The findings included.

1. When passing ice on unit 1 (side 1) the facility staff placed the ice scoop into the ice chest with the handle touching the ice and left the ice chest unattended and open.

On 11/09/16 at approximately 8:00 a.m. the

The hospitality aide is no longer employee at the facility.

The DON in-serviced nursing staff on 11/28/16 regarding passing ice and dermatology issues.

The QA Nurse/designee will complete skin sweeps to identify dermatology issues 5 residents x 4 weeks, 3 residents x 4 weeks, and 1 resident x 4 weeks.

The Director of Nursing/designee will audit passing ice 3 x per week x 4 weeks, 1 x per week x 3 weeks, 3 x per week x 2 weeks, and then 1 x per week x 1 week.

4. The Director of Nursing/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.

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surveyor observed an open ice chest in the hallway on unit 1. There was no staff person nearby this ice chest. When the surveyor looked inside the chest they were able to observe ice and an ice scoop that was lying on top of the ice with the handle touching the ice.

When the hospitality aide returned to this ice chest the surveyor asked them if they usually left the lid open with the scoop inside. The hospitality aide verbalized to the surveyor that she had forgotten she had left the chest open and she did not usually leave the ice scoop in the cooler.

On 11/10/16 at approximately 8:40 a.m. the surveyor interviewed the designated infection control nurse. When asked if the staff should leave the ice scoop on top of the ice and the lid to the chest open the infection control nurse stated No, the ice chest should have been closed and the ice scoop should have been placed in the holder.

The administrative staff were made aware of the above issue during a meeting with the survey team on 11/09/16 and again on 11/10/16.

The facility policy/procedure titled "Infection Prevention and Control Program" read in part "This facility has developed and maintains an infection prevention and control program that provides a safe, sanitary, and comfortable environment to help prevent the development and transmission of infection..."

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

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2. The facility staff failed to include the communicable disease, scabies, on the facility infection control log. Scabies affected Resident #19.

Resident #19 was admitted to the facility on 09/06/12 and readmitted on 10/14/16. Diagnoses included but not limited to Alzheimer's disease, bipolar disorder, schizophrenia, insomnia, constipation and colon cancer.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/21/16 coded the Resident as 2 out of 15 in section C, cognitive patterns. This is a quarterly MDS.

Surveyor reviewed the facility "Infection Log" for the month of October. Resident #19's case of scabies was not found on the log.

Surveyor spoke with the infection control nurse on 11/10/16 at approximately 1030. Surveyor asked the infection control nurse if scabies was considered an infection and infection control nurse stated that it was. Surveyor asked infection control nurse if Resident #19's case of scabies should have been included on the infection control log and she stated she had only been told to put antibiotics on the infection control log.

Surveyor requested and was provided with a copy of facility "Infection Prevention and Control Program" policy which read in part "This facility has developed and maintains an infection prevention and control program that provides a safe, sanitary, and comfortable environment to help prevent the development and transmission of infection. This program will: Maintain records of incidents and corrective actions related to

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F 441	Continued From page 61 infection prevention and control." The issue of not including scabies on the infection control log was discussed with the administrative team during a meeting on 11/10/16 at approximately 1515. No further information provided prior to exit.	F 441		12/09/16
F 502 SS=D	483.75(j)(1) ADMINISTRATION 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 laboratory tests for 2 of 25 residents, Residents #5, #15. The finding included: 1. The facility staff failed to obtain physician ordered laboratory tests a CBC (complete blood count) and CMP (comprehensive metabolic panel) lab test for Resident #5. Resident #5 was admitted to the facility 3/17/06 and readmitted on 8/29/16 with diagnoses that included but not limited to high blood pressure, thyroid disorder, heart failure, esophageal reflux disorder, depression, and manic depression. A review of Resident #5's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 8/10/16, the	F 502	1. Resident #1 physician notification of labs not being complete as ordered and clarification order received 11/10/16 by the licensed nurse. Resident #15 physician notification of labs not being complete as ordered and clarification order received 11/10/16 by the licensed nurse. 2. A facility wide audit was completed on 11/22/2016 by the Interim Director of Nursing and Director of Nursing for the past 3 months beginning September 2016. Residents identified received clarification orders from the physician. A facility wide lab audit was completed on 12/2/2016 by the Director of Nursing, QA nurse, and Unit Manager to ensure each current physician order is completed with medication, dosage, route, and frequency. Residents identified received clarification orders from the physician. The Director of Nursing in-serviced licensed nursing staff on 11/28/16 regarding obtaining labs as ordered by the physician. Education included the lab process and procedure.	

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facility staff assessed the resident to understand and to usually be understood. She was assessed to have a cognitive summary score of 03.

On 11/8/16, a review of Resident #5's clinical record revealed that the physician had given an order on 9/9/16 for a CBC and CMP in am.

A review of the laboratory reports in Resident #5's clinical record revealed no results for the laboratory test.

On 11/8/16 at 3:35 pm, the quality assurance nurse (QA) nurse was asked to assist with locating the missing lab test. She said she would check the closed chart.

On 11/9/16, during a meeting with the administrator, and director of nurses were informed of the missing CBC and CMP laboratory tests.

On 11/10/16 at 2:00 pm the QA nurse informed the surveyor " it wasn ' t there it ' s a missed lab. "

Prior to exit on 11/10/16, the above information was again discussed with the administrator and the director of nurses.

2. The facility staff failed to obtain physician ordered labs for Resident #15.

Resident #15 was admitted to the facility on 7/4/16 with the following diagnoses of, but not limited to high blood pressure, diabetes, arthritis, chronic obstructive pulmonary disease, chronic pain and muscle weakness. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/11/16,

The Director of Nursing/designee will audit lab orders 5 x per week x 4 weeks, 3 x per week x 4 weeks, and then 1 x per week x 4 weeks.

4. The Director of Nursing/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.

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Resident #15 was coded as having a BIMS (Brief Interview for Mental Status, an assessment tool) score was 15 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 1 staff member for personal hygiene and bathing.

During the clinical record review on 11/10/16, the surveyor noted a physician order dated for 10/12/16 which stated " CBC, CMP and Sed rate on 10/17/16 " . The surveyor reviewed the electronic record as well as the paper clinical record and could not find any results for these physician ordered labs.

The director of nursing was notified of the above documented findings at 2:30 pm on 11/10/16.

At approximately 3:15 pm, the surveyor was provided a copy of the nurses ' note time and dated for 11/10/16 at 2:58 pm which stated " Labs that were ordered for 10/17, CBC, CMP and Sed Rate was not obtained ... "

At approximately 3:15 pm in the conference room, the administrative staff was notified of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 11/10/16.

F 514 SS=D 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

F 514

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and

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systematically organized.

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

This REQUIREMENT is not met as evidenced by:
Based on Resident interview, staff interview, clinical record review and facility document review the facility staff failed to ensure a complete and accurate record for 2 of 25 Residents, Residents #7 and #1.

The findings included:

1. For Resident #7, the facility staff failed to ensure accurate documentation of bowel movements.

Resident #7 was admitted to the facility on 09/17/13 and readmitted on 07/15/15. Diagnoses included but not limited to hypertension, anxiety, depression, post-traumatic stress disorder, insomnia, gastroesophageal reflux disease, dementia, psychotic disorder, and schizoid disorder.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 09/27/16 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS.

Resident #7's clinical record was reviewed on 11/08/16. It contained a signed POS (physician's

1. Resident #7 assessed on 11/10/16 by a licensed nurse and found to be stable with no negative outcome as a result of the alleged deficient practice. The bowel protocol is currently in place.

For resident #1 a progress note was provided 1/15/16. The resident has since discharged from the facility.

2. A facility wide bowel movement audit was complete on 12/2/16 by the Director of Nursing, QA nurse, and Unit Managers. Residents identified to need the bowel movement protocol were placed on the program.

A facility wide audit of progress notes was complete on 11/30/16 by the Medical Records Director. There were no other clinical records identified of the alleged deficient practice.

3. The Director of Nursing in-serviced nursing staff 11/28/16 regarding assessment and documentation of the Bowel Protocol.

The Administrator in-serviced the Medical Records Director 11/28/16 regarding progress notes in the clinical record.

The Director of Nursing/designee will audit the Bowel Movement Report daily x 4 weeks, 3 x week x 4 weeks, and then 1 x week x 4 weeks.

The Medical Records Director/designee will audit 5 residents x 4 week, 3 residents x 4 weeks, and the 1 resident x 4 weeks.

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order summary) which read in part "K59.00 Constipation, unspecified COLACE 100 MG CAPSULE TAKE 2 CAPS (200 MG) BY MOUTH EVERY DAY" and "K59.00 Constipation, unspecified GLYCOLAX POWDER GIVE 17 GM IN 8 OUNCES OF LIQUID BY MOUTH EVERY DAY AS NEEDED FOR CONSTIPATION".

Resident #7's clinical record also contained "BM (bowel movement) Record Roster" for the months of August, September, October and November 2106. For the month of August, the BM record indicated a period of 5 days (08/25-08/29/16) with no recorded BM's for Resident #7. For the month of September, the BM record indicated a period of 8 days (09/10-09/17/16) and a period of 7 days (09/25-10/01/16) with no recorded BM's. For the month of October, the BM record indicated two periods of 5 days each (10/08-10/12/16 and 10/21-10/25/16) with no recorded BM's.

Resident #7's MAR's (medication administration record) for the months of August, September, October and November were reviewed. The MAR's contained entries which read in part "Constipation, unspecified COLACE 100 MG CAPSULE TAKE 2 CAPS (200 MG) BY MOUTH EVERY DAY " and "GLYCOLAX POWDER GIVE 17 GM IN 8 OUNCES OF LIQUID BY MOUTH EVERY DAY AS NEEDED FOR CONSTIPATION". The entry for Colace had been signed as having been administered as ordered. The entry for the glycolax had not been signed at any time to indicate that it had been administered as needed.

The Resident's clinical record also contained copy of the facility "Bowel Protocol" which read in part "No BM x 2 days-Please administer 30ml

4. The Director of Nursing/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.

The Medical Records Director/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.

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Milk of Magnesia q.h.s. x 1 at bedtime. No BM x 3 days- Please administer Dulcolax suppository x 1 at bedtime. No BM x 4 days-Please administer Fleets enema x 1 at bedtime. Bowel movement documentation will be reviewed by the 2-11 charge nurses for each unit and medication administered per review of the BM record for each Resident. All laxatives will require documentation on MAR fro (sic) that Resident."

The surveyor could not locate any supporting documentation to indicate that the bowel protocol had been instituted for Resident #7.

Surveyor spoke with LPN #1 on 11/09/16 at approximately 1130 regarding Resident #7. LPN #1 stated that the MAR indicated the last time Resident had received glycolax was 06/22/16. LPN #1 also stated that she had not administered glycolax to Resident over the last month.

Surveyor spoke with Resident #7 on 11/09/16 at approximately 1145 regarding constipation. Resident stated " I don't generally have a problem with constipation because I take Colace regularly and if I go more than 2 days without a BM, I tell the nurse and she gives me milk of magnesia". Surveyor asked Resident if she ever got glycolax and Resident stated "I don't like that stuff, I would rather have the milk of mag, so that ' s what I ask for".

The concern of the inaccurate documentation of BM's was discussed with the administrative team during meeting on 11/09/16 at approximately 1410.

No further information was provided prior to exit.

2. The facility staff failed to maintain progress

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notes in the clinical record of Resident #1.

Resident #1 was originally admitted to the facility on 6/12/13 but has a readmission date back to the facility on 10/26/16. On the quarterly MDS (Minimum Data Set) with and ARD (Assessment Reference Date) of 9/27/16, Resident #1 was coded as having a BIMS (Brief Interview for Mental Status, an assessment tool) score of 5 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 2 staff members for personal hygiene and being totally dependent on 2 staff members for bathing.

A clinical record review was performed by the surveyor on 11/8 and 11/9/16. The surveyor noted that there were progress notes in the paper clinical record dated for 10/20/15 then the next one was dated for 2/26/16. The surveyor also reviewed the electronic clinical record and could not find any further progress notes for Resident #1.

The QA (Quality Assurance) nurse #1 was notified of the above documented findings on 11/9/16 at 11 am. The QA nurse #1 stated " Let me go see if we have a copy of another physician progress note during that time frame and I will also call the physician to ask to see if he might have it with him. I will let you know what I find out. "

At approximately 3 pm in the conference room on 11/9/16, the administrative staff was notified of the above documented findings.

On 11/10/16 at 8:55 am in the conference room, the Q nurse #1 provided a copy of a progress note dated for 1/15 16 for Resident #1. The

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F 514	Continued From page 68 surveyor asked QA nurse #1 were this progress note was found and she stated " This was on the doctor ' s jump drive. But this was not in the facility that we could find. " No further information was provided to the surveyor prior to the exit conference on 11/10/16.	F 514		12/09/16
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520	1. No residents were cited for this alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. 3. The Administrator and Director of Nursing in-serviced the Medical Director on 11/15/16 regarding requirements of the Medical Director's attendance to the QA Committee. The Administrator/designee will audit the Medical Directors attendance for the next 3 quarters of QA meetings. 4. The Administrator/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.	

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F 520	Continued From page 69 Based on staff interview, and facility document review, the facility staff failed to maintain a quality assessment and assurance (QA) program which met regulatory requirements. A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff and which meets at least quarterly. The surveyor met with the administrator on 11/10/16 to review the QA program. The administrator was new and had only been at the facility a little more than a month. While acquainting herself with her new position, she discovered the medical director had attended only one QA meetings in 2016. The administrator, provided the sign in documentation, for monthly QA meetings held in 2016. The Medical Director did attend the January QA meeting. Review of the QA meeting attendance record confirmed the physician had only attended the January meeting in 2016. The surveyor concluded there was no evidence that the full committee, including the physician member, had met quarterly to address QA issues identified by facility staff. Prior to exit no further information was provided to the surveyor related to the QA meetings.	F 520		12/09/16