STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-BATTLEFIELD PARK	250 FLANK ROAD PETERSBURG, VA 23805

(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 An unannounced Medicare/Medicaid standard survey was conducted 03/17/2015 through 03/19/2015. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey The census in this 120 certified bed facility was 115 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents #1 through #20 and #25) and 4 closed record reviews (Residents #21 through #24).	F 000	F278 Criteria #1 -Resident # 11's MDS was modified for accurate coding of antipsychotic medication. -Resident # 5's MDS was modified for accurate coding of pressure ulcer. Criteria #2 -Facility will review 100% of residents' MDS assessment s in the last 30 days for MDS coding accuracy and modifications will be completed as indicated. Criteria #3 -MDS staff will receive education related to accuracy of MDS coding. Criteria #4 -DNS/Designee will complete random audits for MDS accuracy weekly for one month, then monthly for three months. -DNS/Designee will report audit results to QA committee monthly for three months and then as indicated as determined by committee. Criteria 5 -Date of compliance 5/1/2015	
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	F 278		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charles E Phillips | TITLE: Executive Director | (X6) DATE: 4-10-15

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

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F 278	Continued From page 1 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 for 2 resident (Resident #11 and #5) of 25 residents in the survey sample to complete an accurate Resident Assessment Instrument (RAI) Minimum Data Set (MDS) assessment. 1. Resident #11's admission MDS, under Medication Administration, was coded incorrectly. This section did not include coding during the ARD (assessment reference date) of 1/30/15, for the antipsychotic medication that was administered. 2. For Resident #5, the facility staff coded a diabetic foot ulcer as a Stage III pressure ulcer on the most recent quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/21/15. The findings included: 1. Resident #11 was admitted to the facility 1/23/15 with the diagnoses of, but not limited to, hypertension, diabetes, arthritis, cerebrovascular accident, non-Alzheimer's dementia, depression, and altered mental status.	F 278		

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F 278	Continued From page 2 Resident #11's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/30/15 was coded as an admission assessment. Resident #11 was coded a BIMS (Brief Interview of Mental Status) score of 13, cognitively intact. Resident #11 was also coded as requiring extensive physical assistance with her activities of daily living. Resident #11 was coded as having no indicators of Psychosis or Behavioral symptoms. In Section 0410. Medications Received during the last 7 days (1/24/15-1/30/15), Resident #11 was coded for having received diuretics and antidepressant medications. It was coded that Resident #11 received no (zero) antipsychotic medication during the ARD period. Review of Resident #11's clinical record revealed an EMAR (electronic medication administration record) for January 2015 with an entry that read, "Haloperidol Tablet 1 mg (milligram), Give .5 tablet by mouth at bedtime related to ALTERED MENTAL STATUS, 1/23/15. Resident #11's EMAR was documented for the administration of the Haloperidol (Haldol) on the following dates during the ARD period, 1/25, 1/26, 1/27, 1/28, 1/29, and 1/30. "Haloperidol is an antipsychotic medicine. It works by changing the actions of chemicals in your brain." www.drugs.com. Review of Resident #11's physician orders, revealed a corresponding order for the administration of the Haloperidol, with an order and start date of 1/23/15. On 3/18/2015, at 11:30 a.m., Administration	F 278		

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F 278	Continued From page 3 (Admin) D, an RN (registered nurse) consultant, was informed of Resident #11's administration of an antipsychotic that was not coded as such in her admission MDS. After researching the concern, Admin. D stated, "The admission MDS has now been modified to include seven days of medication administration of the Haldol." Admin. D provided documentation indicating the medication was also administered on 1/24/15, even though the EMAR was not documented as Haldol having been administered on that day. The administrator, director of nursing, and nurse consultant were informed of the incorrect coding of Resident #11's antipsychotic medication on the MDS, 3/19/15 at 11:35 a.m. 2. For Resident #5, the facility staff coded a diabetic foot ulcer as a Stage III pressure ulcer on the most recent quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/21/15. Resident #5, a female, was admitted to the facility 4/13/07. Her diagnoses included dementia, hypertension, anemia, type II diabetes mellitus, constipation and ulcer on lower limb. Resident #5's most recent MDS with an ARD of 1/21/15 was coded as a quarterly assessment. Resident #5 was coded as having long and short term memory deficits and required total assistance with making daily life decisions. She	F 278		

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F 278	Continued From page 4 was also coded as needing extensive to total assistance of one to two staff members to perform her activities of daily living. Resident #5 was coded as having one stage III pressure ulcer. The pressure ulcer was described as having granulation tissue in the base and was .4 cm (centimeter) by .4 cm in size. According to the NPUAP (National Pressure Ulcer Advisory Panel) a stage III pressure ulcer is defined as: "Stage III: Full-thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Further description: The depth of a Stage III pressure ulcer varies by anatomic location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage III pressure ulcers. Bone/tendon is not visible or directly palpable." Documentation within Resident #5's clinical record revealed when initially developed, the area on Resident #5's foot was felt to be a pressure area. After being evaluated by the podiatrist, the physician, and the interdisciplinary team the area was determined to be a diabetic foot ulcer, according to LPN (licensed practical nurse) C, the wound care nurse 3/18/15 at 9:05 a.m. The wound care orders written between December, 2014 and when the ulcer was healed in March, 2015 were for treatment of a diabetic foot ulcer.	F 278		

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F 278	Continued From page 5 When interviewed RN (registered nurse) B stated 3/18/15 at 9:12 a.m., she would have to review the supporting documentation to determine about the coding of the area. At 9:20 a.m., RN B stated the pressure ulcer had been miscoded and should have been coded as a diabetic ulcer. The administrator, DON (director of nursing), and corporate consultant were informed of the miscoding of Resident #5's diabetic foot ulcer on the quarterly MDS with an ARD of 1/21/15, 3/19/15 at 11:40 a.m.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	F280 Criteria 1 -Resident # 7's fall care plan was revised to reflect the hipsters were discontinued. -Resident # 20's fall care plan was revised to reflect the wanderguard was discontinued. Criteria 2 -Facility will review 100% resident care plans accuracy and revise as indicated to reflect residents' current plan of care. Criteria 3 -Nursing Staff , MDS , and Interdisciplinary team members will receive education related to reviewing and revising care plans. -Nurse Management, MDS, and Interdisciplinary team members will review and revise care plans as indicated with changes in plan of care and verified with daily clinical meeting.	

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F 280	Continued From page 6 by: Based on observation, staff interview, and clinical record review, the facility staff failed to review and revise the comprehensive plan of care for two Residents (Residents' #7 and #20) in a survey sample of 25 Residents. 1. For Resident #7, the care plan for injury from falls was not revised when "hipsters" were discontinued; and 2. The facility staff failed to remove the use of a wanderguard from Resident #20's fall care plan, after it's use was discontinued by the physician. The findings included: 1. For Resident #7, the care plan for injury from falls was not revised when "hipsters" were discontinued. "Hipsters" are padded briefs utilized to prevent injury during a fall. Resident #7, a female, was admitted to the facility 9/10/08. Her diagnoses included senile dementia, anxiety, aortic atherosclerosis, anemia, unspecified psychoses, depression, cancer breast, hypothyroidism, osteoarthritis, coronary artery disease, hypertension, and gastroesophageal reflux disease. Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/23/14 was coded as a quarterly assessment. She was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #7 was coded as needing extensive to total assistance of one staff member for all of her activities of daily living. She was also coded as having two falls	F 280	Criteria 4 -DNS/designee will complete Random audit of care plans weekly for one month, then monthly for three months by -DNS/designee will report audit results to QA committee monthly for three months and then as indicated as determined by committee. Criteria 5 -Date of compliance 5/1/2015	

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F 280	Continued From page 7 without injury since the previous MDS assessment. Resident #7 was observed 3/17 at 4:04 p.m., 3/18 at 10:05 a.m. and 3:15 p.m. At all three observations, no hipsters were observed on Resident #7. Review of Resident #7's clinical record revealed within the comprehensive plan of care an entry for "Focus: At risk for falls related to Wandering, Use of medication, History of falls...Resident has poor judgement and safety awareness." Included in the "Interventions" was "Hipsters to be worn." CNA (certified nursing assistant) A was interviewed 3/18/15 at 3:20 p.m. CNA A stated she had cared for Resident #7 since being hired at the facility, a couple of months ago. CNA A said she did not know anything about Resident #7 wearing "hipsters," she only knew she used a "lap buddy" to prevent her from falling from her chair. A lap buddy was a device that was soft foam that fit around the front of the wheelchair. The lap buddy prevented Resident #7 from being able to stand easily. CNA A said she had been informed by her coworkers and the nurses of how to care for Resident #7. When interviewed RN (registered nurse) A, the unit manager, said 3/19/15 at 9:52 a.m., the hipsters had been discontinued 3/27/14. RN A said the hipsters had not been discontinued on the care plan. The care plan should be updated by MDS staff or during nursing stand up meeting, held daily, according to RN A. The administrator, DON (director of nursing), and corporate consultant were advised of the failure	F 280		

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F 280	Continued From page 8 of the staff to review and revise Resident #7's care plan after hipsters had been discontinued 3/27/14, 3/19/15 at 11:40 a.m. 2. The facility staff failed to remove the use of a wanderguard from Resident #20's fall care plan, after it's use was discontinued by the physician. Resident #20 was admitted to the facility on 5/13/05 with the diagnoses of, but not limited to, Alzheimer's disease, hypertension and diabetes mellitus. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/4/15. The MDS coded Resident #20 with long and short term memory problems; moderately impaired cognition; required extensive assistance from staff for bed mobility and eating and was dependent of staff for all other activities of daily living. On 3/19/15 at 9:10 a.m., Resident #20 was observed sitting in a rocker wheelchair in her bedroom. Resident #20 did not verbally respond when greeted but opened her eyes and made eye contact. She did not have any observed safety devices on her or the wheelchair. Review of Resident #20's clinical record revealed a care plan for "At risk for falls" with an intervention of a "wanderguard bracelet in place as ordered." A wanderguard is a bracelet like transmitter device worn by the resident which sounds an alarm by exit doors to help prevent elopements. At 9:15 a.m. on 3/19/15, an interview was	F 280		

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F 280	Continued From page 9 conducted with Unit Manager Licensed Practical Nurse-A (LPN-A). LPN-A was questioned if Resident #20 wore a wanderguard and accompanied surveyor to the resident's room. It was observed that there was no wanderguard on Resident #20 nor on her wheelchair. LPN-A proceeded to look on the computerized physician's orders and stated there was no order for a wanderguard. When asked if Resident #20 was an elopement risk, LPN-A stated "Not now." On 3/19/15 at 9:25 a.m., an interview was conducted with the Assistant Director of Nursing (Admin-C). When asked who updates the care plans, Admin-C stated "MDS and the nurses can." On 3/19/15 at 9:45 a.m., LPN-A presented a physician's order dated 12/30/13 revealing the wanderguard had been discontinued. When asked if this was a documentation error, LPN-A stated "Yes it was." The Administrator and Director of Nursing were informed of the findings on 3/19/15 at approximately 11:45 a.m. The facility staff did not present any further information regarding the findings.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281	F281 Criteria 1 -Residents # 1, 4, 8, 15,23,6, and 11's Physician will be notified that medications and treatments were not documented as provided and/or administered per Physician's orders. Criteria 2 -All residents MARs/TARs for the last 30 days will be reviewed for omissions. MD notification and staff counseling will be completed as indicated. -Licensed Nurses will receive education related to Medication Administration Guidelines. -Licensed Nurses responsible for medication/treatment omissions will receive counseling related to not adhering to policies and procedures for medication/treatment administration.	

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F 281	Continued From page 10 Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure professional standards of nursing were followed for medication and treatment administration for 7 Residents (#1, 4, 8, 15, 23, 6, 11) of 25 residents in the sample. 1. Resident #1 had multiple areas where physician ordered care and treatments were not documented as administered. 2. Resident #4 had multiple areas where physician ordered care and treatments were not administered. 3. Resident #8 had multiple areas where physician ordered care and treatments were not documented as administered. 4. For Resident #15, the facility staff failed to document treatments as having been administered. 5. For Resident #23, the facility staff failed to document treatments as having been administered. 6. For Resident #6, the facility staff failed to document the administration of medication and treatments on several dates. 7. For Resident #11, the facility staff failed to document Haloperidol (an antipsychotic), Ropinirole (for restless leg syndrome), and Trazodone (for sleep) as having been administered on 1/24/2015 The findings included: 1. Resident #1 had multiple areas where physician ordered care and treatments were not documented as administered Resident #1, an 81 year old female, was admitted to the facility on 6/13/2013. Her diagnoses included multiple joint contractures, Alzheimer's, hypertension, and high cholesterol. Resident #1's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/26/2015	F 281	Criteria 3 -Licensed Nurses will be educated and responsible for verifying the EMAR/ETAR that Dashboard indicators for completion of administration are green prior to the end of their shift. -Nurse Managers will be responsible for reviewing EMAR/ETAR compliance daily and address identified deficits as indicated. -Facility policies for disciplinary action will be implemented for Licensed Staff that do not adhere to medication administration guidelines. Criteria 4 -EMAR/ETAR documentation will be reviewed daily during clinical meeting and documentation omissions addressed as indicated. -DNS/Designee will be responsible for ensuring the daily review of EMAR/ETAR documentation in Clinical meeting.- -DNS/designee will report audit results to QA committee monthly for three months and then as indicated as determined by committee.	

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F 281	Continued From page 11 was coded as a quarterly assessment. A BIMS score was unable to be obtained on Resident #1, and thus she was coded as having severely impaired cognitive skills by a staff assessment. Resident #1 was also coded as having total dependence of one staff member for her activities of daily living. She was also coded as being always incontinent of bowel and bladder. On 3/18/2015 at 1130 AM, a review of the clinical record revealed a TAR (Treatment Administration Record) for January and March 2015 showing no documentation for the following treatments per physician orders on the dates and times indicated: "Abdominal binder at all times every shift for peg tube"-Night shift 1/9, 1/14, 1/23, 1/25, 3/10, 3/11. "Aquacell-Ag Hydrofiber Pad 4. Apply to right trochanter apply topically every day shift for wound. Wash with soap and water and apply Aquacell AG."-Day shift 3/9. "Bilateral ½ side rails to assist with bed mobility and positioning every shift."-Night shift 1/9, 1/14, 1/23, 1/25, 3/10, 3/11. "MA 65 mattress every shift for pressure ulcer"-Night shift 1/9, 1/14, 1/23, 1/25, 3/10, 3/11. On 3/18/2015 at 12:15 PM, an interview was conducted with RN A, Unit Manager who offered no explanation for the missing documentation. Guidance for nursing practice for following physicians' orders is included in Potter and Perry, Fundamentals of Nursing 7th Edition page 336. "The physician is responsible for directing medical treatment. Nurses follow physician orders unless they believe the orders are in error or harm clients." On 3/19/2015 at 12:15 PM, the administration was informed of the findings. 2. Resident #4 had multiple areas where	F 281	Criteria 5 -Date of compliance 5/1/2015	

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(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 281	Continued From page 12 physician ordered care and treatments were not documented as administered. Resident #4, a 67 year old male, was admitted to the facility on 10/9/2014. His diagnoses include CVA (cerebral vascular accident-stroke), acute kidney failure, high cholesterol, aphasia, and hypothyroidism. Resident #4's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/7/2015 was coded as a quarterly assessment. Resident #4 was coded a BINS (Basic Interview of Mental Status) score of 0, indicating severe cognitive impairment. Resident #4 was also coded as needing extensive assistance of one person for activities of daily living. He was coded as being always incontinent of bowel and bladder. On 3/18/2015 at 3:00 PM a review of the clinical record revealed a TAR (Treatment Administration Record) for January, February, and March 2015 showing no documentation for the following treatments per physician order on the dates and times indicated: "Lap buddy due to safety awareness/poor judgment in which resident has muscle weakness and resident requires upper extremity support due to tendency to lean forward and history of falls." -Day shift 2/12. "Remove lap buddy from wheelchair for 10 minutes every hour and at meal times every shift"-Night shift 1/9, 1/14, 1/25, 2/12, 3/10, 3/11. "Bactroban Ointment (Mupirocin)-Apply to right outer foot topically every day and evening shift for callous to right outer foot with pinpoint hole and drainage. Clean with normal saline and apply Bactroban and cover with dry dressing." -Day shift 2/12. On 3/18/2015 at 4:00 PM an interview was conducted with RN A, Unit Manager who offered no explanation for the missing documentation.	F 281		

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	495252	A. BUILDING _____ B. WING _____	03/19/2015

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F 281	Continued From page 13 Guidance for nursing practice for following physicians' orders is included in Potter and Perry, Fundamentals of Nursing 7th Edition page 336. "The physician is responsible for directing medical treatment. Nurses follow physician orders unless they believe the orders are in error or harm clients." On 3/19/2015 at 12:15 PM, the administration was informed of the findings. 3. Resident #8 had multiple areas where physician ordered care and treatments were not documented as administered. Resident #8, a 90 year old female, was admitted to the facility on 2/28/2014. Her diagnoses include Alzheimer's, depression, and hypertension. Resident #8's MDS (Minimum Data Set) with an ARD (assessment reference date) of 2/3/2015 was coded as an annual assessment. Resident #8 was coded a BIMS (Basic Interview of Mental Status) score of 3, indicating severe cognitive impairment. Resident #8 was also coded as needing extensive assistance of one person for activities of daily living and being always incontinent of bowel and bladder. On 3/18/2015 at 9.00 AM, a review of the clinical record revealed a TAR (Treatment Administration Record) for January, February, and March 2015 showing no documentation for the following treatments per physician orders on the dates and times indicated: "Bilateral ½ side rails up when in bed for support and positioning every shift."-Night shift 1/9, 1/14, 1/23, 1/25, 2/2, 3/10, 3/11. Day shift 2/2, 2/12. "Wanderguard every shift"-Night shift 1/9, 1/14, 1/23, 1/25, 2/2, 3/10, 3/11. Day shift 2/2, 2/13. On 3/18/2015 at 12:15 PM an interview was conducted with RN A, Unit Manager who offered	F 281		

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F 281	Continued From page 14 no explanation for the missing documentation. Guidance for nursing practice for following physicians' orders is included in Potter and Perry, Fundamentals of Nursing 7th Edition page 336. "The physician is responsible for directing medical treatment. Nurses follow physician orders unless they believe the orders are in error or harm clients." On 3/19/2015 at 12:15 PM, the administration was informed of the findings. 4. For Resident #15, the facility staff failed to document treatments as having been administered. Resident #15, a female, was admitted to the facility 5/19/10. Her diagnoses included below knee amputation, ischemic heart disease, diabetes mellitus, chronic obstructive pulmonary disease, hepatitis, osteoporosis, peripheral vascular disease, Alzheimer's, depression, and gastroesophageal reflux disease. Resident #15's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3/9/15 was coded as a quarterly assessment. She was coded as having memory deficits and required moderate assistance in making daily life decisions. Resident #15 was also coded as needing extensive to total assistance of one to two staff members to perform her activities of daily living. Review of Resident #15's clinical record revealed no evidence the following treatment was administered on the days noted: "Bilateral 1/2	F 281		

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F 281	Continued From page 15 bed rails to assist with positioning every shift, 2/8/15 day shift and 3/4/15 night shift. A valid physician's order was evident for "Bilateral 1/2 rails to assist with positioning every shift." When interviewed 3/19/15 at 10:10 a.m., ADM C, the ADON (assistant director of nursing) stated the staff should document as soon as they administer medications or treatments. She further stated the computer prompted the staff to administer and document medications, however it did not do that for treatments. ADM C stated the staff has to remember to check and document for their treatments. She also indicated the same standards were in place for treatment administration as for medication administration. Review of the facility's policy entitled "Medication Administration-Preparation and General Guidelines" included: "1). The individual who administers the medication dose records the administration on the resident's MAR (medication administration record) directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications." Guidance for nursing standards for the administration of medication is provided by "Mosby's Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing	F 281		

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F 281	Continued From page 16 Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation." The administrator, DON (director of nursing), and corporate consultant were advised of the failure of the staff to document treatments were administered for Resident #15, 3/19/15 at 11:40 a.m. 5. For Resident #23, the facility staff failed to document treatments as having been administered. Resident #23, a male, was admitted to the facility 2/11/15 and discharged home 3/3/15. His diagnoses included cerebrovascular accident, septicemia, diabetes mellitus, gout, anemia, hyperlipidemia, benign prostatic hypertrophy, and end stage renal disease with hemodialysis. Resident #23's most recent MDS with an ARD of 2/18/15 was coded as an admission assessment. He was coded as having memory deficits and required total assistance with making daily life decisions. He was also coded as needing extensive to total assistance of one staff member to perform his activities of daily living.	F 281		

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F 281	Continued From page 17 Review of Resident #23's clinical record revealed no evidence the following treatments were administered as ordered by the physician: Barrier cream to buttocks and groin after each incontinent episode: 2/22/15 day shift Bilateral 1/2 side rails for positioning and turning every shift: 2/22/15 day shift Bilateral heel lift boots while in bed every shift for soft bilateral heels: 2/22/15 day shift Sure prep pad to bilateral heels for soft bilateral heels: 2/22/15 day shift A valid physician's order was evident for the treatments not documented as having been administered. The administrator, DON, and corporate consultant were advised of the failure of the staff to document treatments as having been administered, 3/19/15 at 11:40 a.m. 6. For Resident # 6, the facility staff failed to document the administration of medications and treatments on several dates. Resident # 6 was admitted to the facility on 9/22/2011 with the diagnoses of, but not limited to, Hypertension, Dementia, Depression, History of Parkinsonism, History of BPH (Benign Prostatic Hypertrophy), GERD (Gastroesophageal Reflux), Pneumonia, Acute Respiratory Failure and PEG (Percutaneous Endoscopic Gastrostomy) tube. The resident has a Do Not Resuscitate Directive. The most recent Minimum Data Set (MDS) was a Quarterly assessment with an Assessment	F 281		

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F 281	Continued From page 18 Reference Date (ARD) of 2/15/2015. The MDS coded Resident # 6 with BIMS (Brief Interview for Mental Status) not scored and staff coded as moderate cognitive impairment; the resident required extensive assistance with activities of daily living; and always incontinent of bowel and bladder. On 3/18/2015 at 9 a.m.(morning), a clinical record review was conducted for Resident #6. The review revealed current signed physicians orders. Review of Resident #6's medication administration records (MARs) and treatment administration records (TARs) revealed the nursing staff failed to document the administration of medications and treatments on several dates to include: March 2015 Medication Administration Record (MAR) revealed missing: Budesonide Suspension 0.5 MG/2 ML (5 milligrams/2 milliliters) 3/7/15 at 9 AM (morning) Budesonide Suspension 0.5 MG/2 ML (5 milligrams/2 milliliters) 3/8/15 at 9 AM (morning) February 2015 Treatment Administration Record (TAR) revealed missing: Santyl Ointment 250 Unit/GM (grams) apply to sacral ulcer missing 2/22/15 Bactriban Ointment to abrasion below right armpit every shift missing 2/22/15 day shift Bilateral Heel lift boots every shift for mushy heels missing five times: 2/2/15 day and night shifts, 2/7/15 day shift, 2/12/15 day shift, 2/22/15 day shift	F 281		

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F 281	Continued From page 19 MA65 Mattress every shift for open area missing on: 2/2/15 day and night shifts, 2/7/15 day shift , 2/12/15 day shift, 2/22/15 day shift Monitor PICC (peripherally inserted central catheter) line site for any signs and symptoms of infection every shift missing 2/12/15 day shift and 2/22/15 day shift. Hydrocolloid dressing to Sacrum every 2 days missing 2/2/15 day shift March 2015 Treatment Administration Record (TAR) revealed: Bacitracin Ointment 500 UNIT/GM (grams) apply to left earlobe: missing 3/8/15 Bacitracin Ointment 500 UNIT/GM (grams) apply to PEG (Percutaneous endoscopic gastrostomy) site: missing on 3/8/15 Santyl Ointment 250 Unit/GM (grams) apply to sacral ulcer missing on 3/8/2015 Monitor PICC (peripherally inserted central catheter) line site for any signs and symptoms of infection every shift missing on 3/10/15 night shift and 3/11/15 night shift. Bilateral Heel lift boots every shift for mushy heels missing 3/10/15 night shift and 3/11/15 night shift MA65 Mattress every shift for open area missing on 3/10/15 night shift and 3/11/15 night shift An interview was held on 3/18/15 at 10:35 AM (morning) with RN A regarding missing documentation. RN A stated the expectation is that documentation of medications and treatments will be done at the time of administration. During the end of day debriefing on 3/18/2015 at	F 281		

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F 281	Continued From page 20 4:15 PM (afternoon), Admin A, Admin C, Admin D were informed of the findings. The surveyor asked about the expectation regarding documentation of administration of medications and treatments. Admin D stated the expectation is that medications and treatments should be documented at the time of administration. Admin D also stated they would investigate to determine if any of the medications and or treatments had been administered. On 3/19/15 at 11:45 AM (morning), Admin D and LPN A presented copies of progress notes which showed documentation of a few treatments included in the nurses notes. Admin D stated the expectation is that medications and treatments should be documented on the medication administration and treatment administration records (MARs and TARs). No further information was provided. Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing: Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time	F 281		

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F 281	Continued From page 21 6. The right documentation." Valid physician's orders were evident for the medications and treatments not documented as administered. 7. For Resident #11, the facility staff failed to document Haloperidol (an antipsychotic), Ropinirole (for restless leg syndrome), and Trazodone (for sleep) as having been administered on 1/24/15. Resident #11 was admitted to the facility 1/23/15 with the diagnoses of, but not limited to, hypertension, diabetes, arthritis, cerebrovascular accident, non-Alzheimer's dementia, depression, and altered mental status. Resident #11's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/30/15 was coded as an admission assessment. Resident #11 was coded a BIMS (Brief Interview of Mental Status) score of 13, cognitively intact. Resident #11 was also coded as requiring extensive physical assistance with her activities of daily living. Resident #11 was coded as having no indicators of Psychosis or Behavioral	F 281		

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F 281	Continued From page 22 symptoms. In Section 0410. Medications Received during the last 7 days, Resident #11 was coded for having received diuretics and antidepressant medications. The MDS was not coded for the receipt of antipsychotic medications during the ARD period. Review of Resident #11's clinical record revealed an EMAR (electronic medication administration record) in which on January 24, 2015 the following medication were not documented as having been administered: "-Haloperidol Tablet 1 mg (milligram) , Give .5 tablet by mouth at bedtime related to ALTERED MENTAL STATUS, 1/23/15. -Ropinirole Tablet 1 mg, Give 2 tablets by mouth at bedtime related to RESTLESS LEGS SYNDROME, 1/23/15. -Trazodone Tablet 50 mg, Give 1 tablet by mouth at bedtime for SLEEP." (1/24/15) Review of Resident #11's physician order, revealed corresponding orders for the administration of the Haloperidol, Ropinirole, and Trazodone, with an order and start date of 1/23/15. On 3/18/2015, at 11:30 a.m., Administration (Admin) D, an RN (registered nurse) consultant, was informed of Resident #11's medications that were not documented as having been administered. After researching the concern, Admin. D said she was informed by the nurses assigned to Resident #11 on the 24th of January that the medications in question were administered, but not documented as such on the EMAR. Admin D provided documentation indicating the medications were available for	F 281		

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F 281	Continued From page 23 administration on 1/24/15, even though the EMAR did not reflect documentation of administration of the medications on that day. Admin. D said it was the expectation for the nurses to document on the EMAR after a medication had been administered. Review of the facility's Medication Administration policy, under documentation read, "The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medication reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications." Additional guidance was provided by, "Fundamentals of Nursing 7th Edition", Potter-Perry, p. 713, "After administering a medication, record it immediately on the appropriate record form. The administrator, director of nursing, and nurse consultant were informed of the findings, 3/19/15 at 11:35 a.m.	F 281		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314	F314 Criteria 1 -Resident # 5's physician ordered preventative measures for pressure ulcer prevention are in place per plan of care.	

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F 314	Continued From page 24 pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to implement physician ordered preventative measures for pressure ulcer prevention for one Resident (Resident #5) in a survey sample of 25 Residents. For Resident #5, the facility staff did not apply heel lift boots as ordered by the physician. The findings included: Resident #5, a female, was admitted to the facility 4/13/07. Her diagnoses included dementia, hypertension, anemia, type II diabetes mellitus, constipation and ulcer on lower limb. Resident #5's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/21/15 was coded as a quarterly assessment. Resident #5 was coded as having long and short term memory deficits and required total assistance with making daily life decisions. She was also coded as needing extensive to total assistance of one to two staff members to perform her activities of daily living. Resident #5 was coded as having one stage III Resident #5 was observed 3/18 at 7:42 a.m. and 3:15 p.m. and 3/19/15 at 8:06 a.m. At all three observations, Resident #5 was lying on her back in bed. The head of the bed was slightly	F 314	Criteria 2 -All residents with physician ordered preventative measures for pressure ulcer prevention will be reviewed for compliance and plan of care review and revisions will be completed as indicated. Criteria 3 -Nursing Staff will be educated related to policies and procedures for following physician's orders for preventative measures for pressure ulcer prevention. -Treatment Nurse will complete weekly observations for compliance of preventative measures for pressure ulcer prevention and provide report to DNS weekly. -Treatment Nurse will be responsible to update CNA care cards for new or changed physician ordered preventative measures. Criteria 4 -Nurse Managers will complete Random weekly audits for verification of compliance of physician ordered preventative measures. -Weekly audits will done weekly x 4 and then monthly for three months. -DNS/designee will report audit results to QA committee monthly for three months and then as indicated as determined by committee. Criteria 5 -Date of compliance 5/1/2015	

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F 314	Continued From page 25 elevated. Resident #5's heels were observed to be flat on her bed and she was wearing white socks on both feet. Review of Resident #5's clinical record revealed she had been determined quarterly to be at risk for the development of a pressure ulcer due to her minimal mobility, dementia, and comorbidities. Additionally Resident #5 had been treated for a diabetic foot ulcer from October, 2014 until the area healed in March, 2015. A physician's order was evident "10/31/14 Bilateral (both feet) heel lift boots while in bed every shift for mushy heels." A corresponding entry was noted on the eTAR (electronic treatment administration record with nurses initials indicating heel lift boots were in place every shift while Resident #5 was in bed. A thorough review revealed the nurses documented heel lift boots were in place on the days and times in question. A heel lift boot is defined as a device that eliminates pressure from the heel by offloading all pressure from the heel and redistributing the pressure to the calf, preventing the development of heel pressure ulcers. RN (registered nurse) C entered Resident #5's bedroom, along with LPN (licensed practical nurse) C, the wound care nurse 3/19/15 at 8:06 a.m. As noted above, Resident #5 was lying on her back in bed, with her breakfast on her over bed table. RN C removed the covers and observed Resident #5's heels lying flat on the bed with no specialty or heel lift boots in place. RN C also removed Resident #5's socks. Her feet were very dry and scaly, no reddened or open areas	F 314		

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F 314	Continued From page 26 were observed on her heels. LPN C stated Resident #5 should have been wearing the specialty boots and searched Resident #5's bedroom to no avail. No heel lift boots were evident in Resident #5's bedroom. The CNA (certified nursing assistant) assisting Resident #5 was unable to be interviewed. RN C stated she did not know where the heel lift boots were that Resident #5 was supposed to be wearing while in bed. She stated she would ensure the boots were found or another pair would be obtained. Review of Resident #5's care plan revealed the interdisciplinary team had assessed Resident #5 for "Risk of altered skin integrity related to impaired mobility and incontinence of bowel and bladder. Resident requires limited to extensive assist for mobility and extensive to total assist for toileting need. (10/4/14 (R-right) foot second digit open areas necrotic with drainage diabetic Ulcer." Included in the "Intervention" was "Heel boots." Additionally on the CNA "Resident Cardex" for Resident #5 was "Bilateral heel lift boots while in bed." The administrator, DON (director of nursing) and corporate consultant were informed of the failure of the staff to apply heel lift boots as ordered for Resident #5, 3/19/15 at 11:40 a.m.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323	F323 Criteria 1 -No resident identified	

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F 323	Continued From page 27 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide a safe environment for one of four units (Wing One, bottom hall). Medications (eye drops) were left on top of the medication cart. The findings included: On 3/18/15 at approximately 8:40 AM, the medication pass was observed. LPN (licensed practical nurse) B prepared Resident #17's medications. It was found that the resident's eye drops were not dated. LPN (B) stated, "I will get some from the back." LPN (B) returned, with two boxes of Systane eye drops. She opened one, dated it, and left the other box on top of the medication cart. Prior to preparing the medications for Resident #17, a male resident was observed taking medication cups from the medication cart. LPN (B) went into Resident #17's room (B bed) and closed the door. The box of Systane eye drops were left on top of the cart. After administering the eye drops, the same male resident was observed wheeling near the medication cart. LPN (B) was questioned about leaving the eye drops on top of the cart. she stated, "Oh, that was ___(name of male resident). No other statement was made.	F 323	Criteria 2 -Medication was removed from cart and stored properly to prevent hazard. Criteria 3 -Licensed Nurse that failed to store medications per policy will be counseled related to safe storage of medications. -Licensed Staff will receive education related to maintaining an environment that is free of hazards related to safe storage of medications.-Nurse Managers will be responsible for monitoring safe storage of medications and to counsel staff as indicated for not adhering to policy for safe storage of medications. Criteria 4 -Nurse Managers will completed audits of environment weekly for four weeks and then monthly for three months related to safe storage of medications. - DNS/designee will report audit results to QA committee monthly for three months and then as indicated as determined by committee. Criteria 5 -Date of compliance 5/1/2015	

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F 323	Continued From page 28 On 3/18/15 at the end of the day exit, the Administrator and DON (director of nursing) were notified of above findings.	F 323		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that – (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that – (i) Before offering the pneumococcal immunization, each resident, or the resident's	F 334	F334 Criteria 1 -Resident #9's flu and pneumonia vaccination status has been reviewed. Physician and family notified, consents received and vaccinations provided per physician's orders. Criteria 2 -All current residents' flu and pneumonia vaccination status will be reviewed and vaccinations will be provided per policy, consent, and physician's orders as indicated. Criteria 3 -Licensed Staff will be educated on flu and pneumonia vaccination policy and procedures. -Nurse Managers will review new admits for resident flu/pneumonia vaccination status and implement vaccination policies as indicated. -ADNS/Designee will review monthly flu and pneumonia vaccination report for flu/pneumonia vaccination needs and will initiate vaccination policy as indicated for identified residents.	

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F 334	Continued From page 29 legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review the facility staff failed for one resident (Resident #9) of 25 residents in the survey sample to administer the flu and pneumonia vaccines as ordered by the	F 334	Criteria 4 -ADNS/Designee will complete random audits for compliance of flu and pneumonia vaccination policy and procedure weekly for one month and then randomly for 3 months.- ADNS/Designee will report audit Results to QA committee monthly for three months and then as indicated as determined by committee.- ADNS/designee will review and report to QA committee all resident flu and pneumonia vaccination outcomes monthly from Oct 1st-March 31st 2015/2016 flu season. Criteria 5 -Date of compliance 5/1/2015	

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F 334	Continued From page 30 physician and consented by the responsible party. For Resident #9, the facility staff failed to administer the flu vaccine, and failed to determine if a pneumonia vaccine was given prior to admission. The findings included: Resident #9 was originally admitted to the facility on 5/23/14 and readmitted on 7/10/14 with the diagnoses of, but not limited to, Mental Retardation (Intellectual Disability), dementia and depression. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/23/15. The MDS coded Resident #9 with long and short term memory problems, moderately impaired cognition; required extensive assistance from staff for bed mobility, transfers and dressing and dependent on staff for eating, toileting, hygiene and bathing. Review of the MDS conducted on 3/18/15, did not reveal when Resident #9 received the influenza (flu) or pneumonia vaccines. On 3/18/15 during a review of Resident #9's clinical record, an "Immunization Consent Or Declination" form was signed by the resident's guardian giving consent for the facility staff to administer the Influenza (flu) vaccine "at admission and annually thereafter" and the Pneumococcal (pneumonia) vaccine "at admission and/or if re-vaccination required." Review of the "Immunization Record" revealed no documentation that the flu vaccine was administered or a previous vaccination date of the	F 334		

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F 334	Continued From page 31 pneumonia vaccine. Review of the current Physician's Orders included: "Resident to receive an annual influenza vaccine." The original vaccine order date was 7/11/14. Facility policy titled "Influenza/Pneumococcal Immunization Guideline" included "Influenza Immunization-The center will administer the influenza vaccine each fall when the vaccine is available to the living center and will continue to be administered throughout the influenza season (October 1 through March 31)..." and "Pneumococcal Immunization: It is the practice of this center to offer and encourage that all residents receive the Pneumococcal immunization unless already previously received. 1. The consent and/or need for the resident to receive the Pneumococcal vaccine will be confirmed per the following: Check the resident's immunization history. a. If the resident is admitted into the center and has no history of ever having received the Pneumococcal vaccine, the vaccine should be administered.. This information will be documented on the immunization log...." On 3/18/15 at 11:40 a.m. an interview was conducted with Unit Manager Licensed Practical Nurse-A (LPN-A). When asked when Resident #9 received the flu and pneumonia vaccines, LPN-A stated "There is no documentation that she received it." The Administrator and Director of Nursing were informed of the findings on 3/18/15 at 4:50 p.m. The facility staff did not present any further information regarding the findings.	F 334		

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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 lab work for one Resident (Resident #7) in a survey sample of 25 Residents. For Resident #7, the facility staff failed to obtain a CBC (complete blood count) on 1/1/15 per physician's orders. Resident #7, a female, was admitted to the facility 9/10/08. Her diagnoses included senile dementia, anxiety, aortic atherosclerosis, anemia, unspecified psychoses, depression, cancer breast, hypothyroidism, osteoarthritis, coronary artery disease, hypertension, and gastroesophageal reflux disease. Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/23/14 was coded as a quarterly assessment. She was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #7 was coded as needing extensive to total assistance of one staff member for all of her activities of daily living. Review of Resident #7's clinical record a signed physician's order, "8/14/14 CBC weekly on Thursdays day shift." The order was on the most	F 502	F502 Criteria 1 -Physician was notified that Resident #7's lab was not completed as ordered per physician's orders. Criteria 2 -All residents with physician ordered labs in the last 30 day will be reviewed for completion as ordered and identified omissions will be addressed as indicated. Criteria 3 -Licensed staff will receive education related to policy and procedures for physician ordered labs. -Lab orders will be reviewed daily in clinical meeting to verify that labs have been processed and completed per physician's orders. Criteria 4 -DNS/Designee will complete random audits weekly for 4 weeks and then monthly to verify labs are completed per physician's orders- -DNS/designee will report audit results to QA committee monthly for three months and then as indicated as determined by committee. Criteria 5 -Date of compliance 5/1/2015	

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F 502	Continued From page 33 recently "Order Summary Report" signed by the physician 2/17/15. A thorough review of Resident #7's clinical record revealed weekly CBCs were obtained with the exception of the week of 1/1/15. The CBC obtained the week before was on 12/26/14 and the next CBC obtained on 1/8/15. RN (registered nurse) A, the unit manager, stated she would review Resident #7's record to see if a CBC had been obtained the week of 1/1/15, 3/19/15 at 10:35 a.m. After reviewing the clinical record, RN A stated no CBC had been obtained that week, of 1/1/15. RN A stated a report is run at the end of the month, for the next month, to determine what lab work needs to be obtained. RN A stated she did not know why the CBC had not been obtained the week of 1/1/15. The administrator, DON (director of nursing), and corporate consultant were advised of the failure of the staff to obtain a weekly CBC, the week of 1/1/15, per physicians orders, 3/19/15 at 11:40 a.m.	F 502		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514	514 Criteria 1 -Resident #6's weekly skin assessment form is accurate per resident's current skin conditions.-Resident # 10's inaccurate documentation of wanderguard in progress note was a documentation error. Resident's record currently reflects that resident does not have a wanderguard.	

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F 514	Continued From page 34 services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure complete and accurate records for 2 residents (Resident # 6 and Resident # 10) in a sample of 25 residents. 1. For Resident # 6, the facility staff failed to ensure the weekly skin assessment forms were accurate as evidenced by failure to document on a pressure ulcer on the sacrum and recent open area on the left earlobe. 2. For Resident #10, a wanderguard was documented in a progress note as being used, however, the physician had discontinued the order. The findings included: 1. For Resident # 6, the facility staff failed to ensure the weekly skin assessment forms were accurate as evidenced by failure to document on a sacral wound and a recent open area on the left earlobe. Resident # 6 was admitted to the facility on 9/22/2011 with the diagnoses of, but not limited to, Hypertension, Dementia, Depression, History of Parkinsonism, History of BPH (Benign Prostatic Hypertrophy), GERD (Gastroesophageal Reflux Disease) and PEG (Percutaneous Endoscopic Gastrostomy) tube.	F 514	Criteria 2 -All residents' skin assessment forms will be reviewed for completeness and accuracy and identified deficits addressed as indicated.-All residents' progress notes who have had a discontinued wanderguard in the last 30 days will be reviewed for completeness and accuracy. Documentation will be completed to reflect the resident status and current plan of care as indicated. Criteria 3 -Nursing Staff and Interdisciplinary Team Members will receive education related to complete and accurate medical records. -Treatment Nurse will review skin assessment forms for completeness and accuracy daily in clinical meeting. -DNS/Designee will review skin assessment forms weekly for accuracy and completeness and identified deficits addressed as indicated. -Administrator/Designee will complete weekly review of two resident records to verify complete and accurate documentation Criteria 4 -Administrator/Designee will complete random audits for complete and accurate medical record weekly for four weeks and then monthly for three months -DNS/designee will report audit results to QA committee monthly for three months and then as indicated as determined by committee.	

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F 514	Continued From page 35 The resident has a Do Not Resuscitate Directive. The most recent Minimum Data Set (MDS) was a Significant Change assessment with an Assessment Reference Date (ARD) of 2/5/2015. The MDS coded Resident # 6 with BIMS (Brief Interview for Mental Status) not scored but staff coded as moderate cognitive impairment; the resident required extensive assistance with activities of daily living; and always incontinent of bowel and bladder. On 3/18/2015 at 9 AM (morning), a review of the clinical record was conducted. Review of the clinical record revealed a discrepancy between the weekly skin assessment sheets dated 3/10/15 and 3/17/15 and the Wound Evaluation Flow Sheets dated 3/9/15 and 3/16/15. Weekly skin integrity review form dated 3/10/15 and 3/17/15 indicated "skin intact" with no open areas marked. Review of the Wound Evaluation Flow Sheets revealed weekly documentation on two separate forms for two pressure areas. One form included documentation on 3/9/15 and 3/16/15 on a sacral wound. The other form measured the progress of an ulcer on the left ear on 3/9/15 and documented "healed" on 3/17/15. The Wound Evaluation Flow Sheet for the open area to the sacrum showed weekly documentation since 12/29/14 including notes dated 3/9/15 which indicated an open area to the sacrum measuring 3.2 x 2.4 x .2 centimeters and on 3/16/15 indicated open area to sacrum measuring 3.0 x 1.6 x .2 centimeters.	F 514	Criteria 5 -Date of compliance 5/1/2015	

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F 514	Continued From page 36 The other Wound Evaluation Form showed weekly documentation since 2/24/15 which included notes dated 3/9/15 that indicated an open area on the left ear measuring .6 x .3 x .1 centimeters. The next documentation on 3/17/15 showed the area on the ear as "healed." An interview was held on 3/18/2015 at 9:20 AM (morning) with the Wound Care Nurse, LPN C (Licensed Practical Nurse C), who stated recent "skin assessments state the skin is intact but the resident is being treated by Physical Therapy now for his sacral wound. The wound progressed and that's why Physical Therapy started to treat it. Those skin assessment sheets are wrong." LPN C also stated that the "area on the ear is healed now." On 3/18/15 at approximately 11 AM (morning), Unit Manager RN A (Registered Nurse A) was informed of the findings. RN A stated the expectation is that the weekly skin assessments should be done weekly and should accurately describe all wounds. Review of the Physicians Orders dated 2/23/15 revealed an order for "Physical Therapy to address wound care to sacral area as follows: Cleanse with Normal Saline, debridement of necrotic tissue, apply Santyl (250 Unit/Gram) and cover with barrier dressing topically on day shift Monday through Friday for 4 weeks. Discontinue date 3/23/15." Review of the Physicians Orders dated 2/24/15 revealed an order for "Bacitracin Ointment 500 Unit/GM(GRAM) Apply to left earlobe topically every day shift for open area to left earlobe, clean with normal saline and apply to left earlobe." The	F 514		

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F 514	Continued From page 37 Wound Assessment Sheet dated 3/17/15 showed the left earlobe is healed. Review of the Treatment Administration Record reveal documentation of the above treatments to both areas including during the timeframe of March 9-17, 2015. Review of the Physical Therapy Progress notes signed 2/24/15 and 3/18/15 indicate that Physical Therapy is treating a sacral wound on Resident # 6. The most recent note dated 3/18/15 the sacral wound is still open but decreased in size. During the end of day debriefing on 3/18/2015 at 4:15 PM (afternoon), Admin A, Admin C, Admin D were informed of the findings. No further information was provided. 2. For Resident #10, a wanderguard was documented in a progress note as being used, however, the physician had discontinued the order. Resident #10 was admitted to the facility on 2/2/09 with the diagnoses of, but not limited to, Alzheimer's dementia, diabetes mellitus type 2 and hypertension. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/23/15. The MDS coded Resident #10 with intact cognition (Brief Interview for Mental Status-BIMS score of 13).	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-BATTLEFIELD PARK	250 FLANK ROAD PETERSBURG, VA 23805

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F 514	Continued From page 38 required set up assistance with most activities of daily living; and was independent with ambulation. On 3/18/15 at 10:40 a.m., Resident #10 was observed sleeping in bed, call bell within reach and with no observed safety alarms in use. Review of Resident #10's clinical record revealed a "Progress Notes" dated 12/2/14 at 12:38 (p.m.) that read: "Social Service Progress Note (reflective of the reference period ending 12/01/2014): (Resident name) is alert with confusion noted....He continues to have a wanderguard as a safety precaution secondary to his confusion." On 3/18/15 at 3:15 p.m., an interview was conducted with Unit Manager Registered Nurse-A (RN-A). When asked about the documentation of Resident #10 having a wanderguard, RN-A stated the "Social Worker added wanderguard to her note in error, it was already D/C'd (discontinued). RN-A presented a Progress Note dated 11/14/2014 which read "MD (medical doctor) aware of resident no longer wandering within facility or making any attempts to go home. New order received to discontinue wanderguard..." On 3/19/15 at 10:30 a.m. Social Worker (Other-A) stated the "Note regarding the wanderguard was just an error." The Administrator and Director of Nursing were informed of the findings on 3/19/15 at approximately 11:45 a.m.	F 514		

Fax Confirmation Report

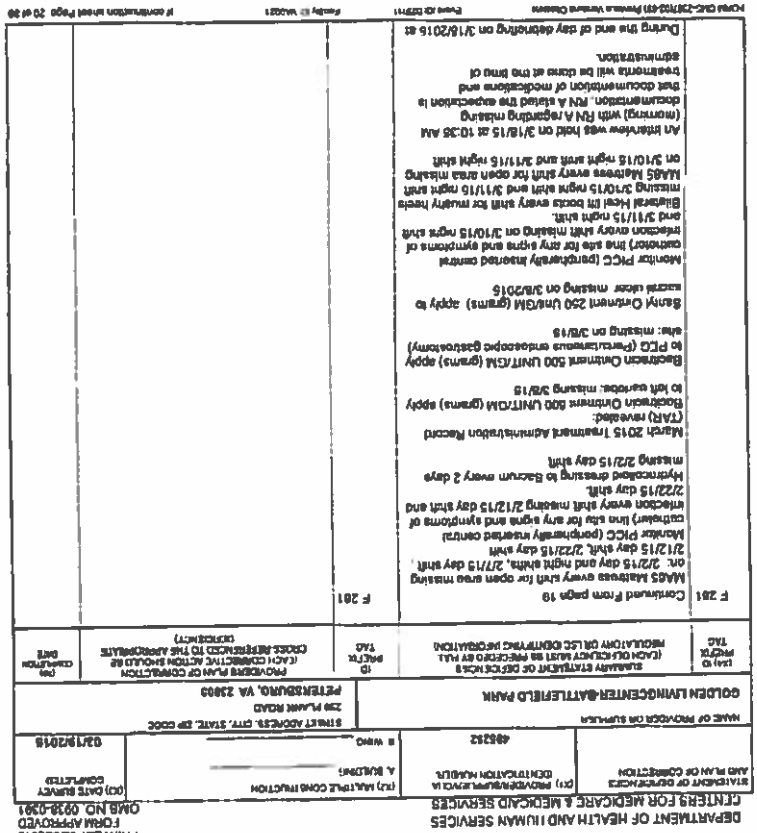
Date/Time : APR-10-2015 02:42PM FRI
Fax Number : 8048618643
Fax Name : copy room
Model Name : Phaser 3635MFP

Total Pages Scanned: 20

No.	Remote Station	Start Time	Duration	Page	Mode	Job Type	Result
001	18045274502	04-10 02:38PM	03'28	020/020	EC	HS	CP

Abbreviations:

HS:Host Send	PL:Polled Local	CP:Completed	TS:Terminated by System
HR:Host Receive	PR:Polled Remote	FA:Fail	TU:Terminated by User
MS:Mailbox Save	WS:Waiting To Send	RP:Report	G3:Group3
MP:Mailbox Print	EC:Error Correct		



Golden Living Center Battlefield Park
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Petersburg, VA 23805
804 861 2223
804 861-8643

[redacted]

Fax

To: Elaine Cacciatore From: KELLY PORTERFIELD

Fax: 804-527-4502 Pages: 44

Phone: Date: 4/10/2015

Re: PLAN of Correction CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

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Elaine.Cacciatore VDH.VA.GOV
LTC Supervisor
Office of Licensure and Certification
Division of Long Term Care Services

Fax Confirmation Report

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Fax Number : 8048618643
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No.	Remote Station	Start Time	Duration	Page	Mode	Job Type	Result
001	18045274502	04-10 02:45PM	03'27	020/020	EC	HS	CP

Abbreviations:

HS:Host Send
HR:Host Receive
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MP:Mailbox Print
PL:Polled Local
PR:Polled Remote
WS:Waiting To Send
EC:Error Correct
CP:Completed
FA:Fail
RP:Report
TS:Terminated by System
TU:Terminated by User
G3:Group3