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	495177	A. BUILDING _____ B. WING _____	03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL	125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970

(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 3/14/17 through 3/16/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. There were no complaints investigated during the survey. The Life Safety Code survey/report will follow.

The census in this 161 certified bed facility was 92 at the time of the survey. The survey sample consisted of sixteen current resident reviews (Residents 1 through 16) and three closed record reviews (Residents 17 through 19).

F 157 SS=D 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

(g)(14) Notification of Changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with the participation requirements.

F 157 Notify of Changed (Injury/Decline, Etc)

Corrective Measure for Residents Affected

The attending physician of Resident # 4 was notified of the healed pressure ulcer on her sacrum and the mepilex dressing was discontinued on 3/15/17.

Identification of Other Residents with Potential To Be Affected

Other residents with potential to be affected were identified through review of the weekly wound reports on 3/24/17. There were no current residents affected.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela Williams	ADMINISTRATOR	3/30/17

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to notify the physician of a change in condition for one of 19 residents in the survey sample. Resident #4's physician was not notified when a pressure ulcer was healed resulting in continued prescribed treatment/dressing changes to the area.

The findings include:

Resident #4 was admitted to the facility on 9/24/16 with a re-admission on 11/18/16.

Measures to Prevent Recurrence

In-service to licensed nurses will be conducted to reiterate the facility's policy for wound care and for notifying the physician of a resident's/patient's change in condition.

Monitoring:

The Director of Nursing (DON) or designee will review the Weekly Wound Report and resident medical record to ascertain if physician has been notified of healing or changes in residents' wounds. Audits will be conducted weekly X 4 then monthly X 2. Findings will be reported to the QAPI Committee and further actions taken as appropriate.

Correction Date: 4/15/2017

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Diagnoses for Resident #4 included Parkinson's disease, chronic dehydration, Crohn's disease, urinary tract infection and left femur fracture. The minimum data set (MDS) dated 12/16/16 assessed Resident #4 as cognitively intact.

Resident #4's clinical record documented the resident was assessed with a stage 2 pressure ulcer on her sacrum from 11/18/16 until 1/25/17. A re-admission nursing assessment dated 11/18/16 documented the resident had a stage 2 pressure ulcer on her sacrum measuring 5 cm x 3 cm x 0 cm (length by width by depth in centimeters). A physician's order dated 11/18/16 stated, "Clean sacrum with normal saline, pat dry, apply Mepilex" with instructions to change the dressing every 3 days. Resident #4's treatment records documented dressing changes to the sacral pressure ulcer every three days as ordered. A nursing note dated 1/25/17 documented the sacral pressure ulcer was healed. A wound assessment record dated 1/25/17 also listed the stage 2 pressure sore as "resolved."

Resident #4's physician was not notified the sacrum pressure ulcer was healed. Treatment records documented continued treatment with the ordered Mepilex dressing every three days to the resident's sacral area from 1/25/17 through 3/12/17 even though the pressure ulcer was resolved. Nursing notes documented no notification to the physician regarding the change in the status of the resident's pressure sore.

On 3/15/17 at 11:20 a.m. the licensed practical nurse (LPN #1) responsible for wound treatments was interviewed about Resident #4's sacral pressure ulcer. LPN #1 stated the resident's

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pressure ulcer healed on 1/25/17. LPN #1 stated she decided to continue the Mepilex dressings as a protective measure. LPN #1 stated she found that sometimes after a pressure ulcer healed the area was tender and had the potential to open back up. When asked if the physician was notified the open pressure ulcer had healed, LPN #1 stated, "I don't see a note notifying the doctor." LPN #1 stated there was no new order received to continue treatment to the resident's sacrum after the sore was resolved. When asked why the physician was not contacted about desired treatment options after the wound had healed, LPN #1 stated, "They give us leeway with that."

The National Pressure Ulcer Advisory Panel (NPUAP) defines a pressure ulcer/sore as "localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear..." This reference defines a stage 2 pressure sore as, "Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present..." (1)

The manufacturer's information insert described Mepilex as a patented adhesive dressing "designed for a wide range of exuding wounds such as pressure ulcers, leg and foot ulcers and traumatic wounds." (2)

These findings were reviewed with the

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administrator and director of nursing during a meeting on 3/15/17 at 4:00 p.m.

(1) NPUAP Pressure Injury Stages. 2016. National Pressure Ulcer Advisory Panel. 3/17/17. www.npuap.org/
(2) Mepilex Border Sacrum. Molnlycke Health Care. Goteborg, Sweden. 2014.

F 252 SS=D 483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

§483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-

(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.

(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.
This REQUIREMENT is not met as evidenced by:

F 252 Safe/Comfortable/Homelike Environment

Corrective Measure for Residents Affected

There were no specific residents cited as having been affected by this citation. The items that were in the day room on the first floor were removed on 3/16/2017.

Identification of Other Residents with Potential To Be Affected

There were no other residents affected. There are three other day rooms in the facility and all three were inspected on 3/16/17 for unnecessary items or equipment and there were none found.

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Based on observation and staff interview, the facility failed to ensure a homelike environment on one of two nursing units. Reclining chairs, wheelchairs and an undecorated Christmas tree were stored in the resident day room on unit. In addition, the piano in the room was not accessible due to reclining chairs stored in front of the instrument.

The findings include:

On 3/15/17 at 3:10 p.m. the day use room on unit 1 was observed when used for a private family interview. This room had a sofa, chairs, a desktop computer, television and a piano for resident use. Stored in the room were two reclining "geri" chairs. The reclining chairs were positioned in front of the piano keyboard making it inaccessible. Three wheelchairs, one with a mounted portable oxygen cylinder, were stored next to the wall near the piano. An undecorated Christmas tree was positioned next to the door at the entrance to the room. On 3/16/17 at 8:45 a.m. the unit 1 resident day use room was observed again. The two reclining chairs were still positioned in front of the piano and three wheelchairs were stored in the room along with the undecorated Christmas tree.

On 3/16/17 at 8:55 a.m. the licensed practical nurse (LPN #3) working on unit 1 was interviewed about the day room. LPN #1 stated the room was intended for residents to use the computer, television or telephone. LPN #3 stated they had other rooms on the unit for the storage of wheelchairs and resident equipment.

On 3/16/17 at 9:00 a.m. the registered nurse clinical coordinator (RN #1) was interviewed

Measures to Prevent Recurrence

In-service to staff regarding the residents' right to a safe, clean, comfortable environment will be conducted. Staff will also be reminded where items/equipment are to be kept when not in use.

Monitoring:

The Director of Nursing or designee will conduct daily inspections of the resident day rooms to ensure they are kept uncluttered. Rounds will be conducted daily X 4 weeks then if no issues are identified, weekly X 2 months. Findings will be reported to the QAPI Committee and further actions taken as appropriate.

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F 252	Continued From page 6 about the resident equipment and undecorated tree in the resident day room. RN #1 stated the room was setup so residents could watch television, use the computer or have private telephone conversations with use of the portable telephone. RN #1 stated the resident equipment in the room should have been stored in designated storage rooms. RN #1 stated she did not know why the Christmas tree had not been taken down or re-decorated. These findings were reviewed with the administrator and director of nursing during a meeting on 3/16/17 at 9:40 a.m.	F 252		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -		**F 279 Develop Comprehensive Care Plans** **Corrective Measure for Residents Affected** Resident # 4's care plan was updated on 3/15/17 to include the intravenous (iv) fluids being administered thru an intravenous line. Care of the site was also included in the care plan update. **Identification of Other Residents with Potential To Be Affected** On 3/23/17, other residents with potential to be affected were identified through review of the care plans of residents with orders for i.v. fluids or medication administration via an i.v. line. Two other residents met the criteria but both have appropriate care plans in place.	

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(i) 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 §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff

Measures to Prevent Recurrence

In-service to nurses and the interdisciplinary care team members regarding the facility's protocol for care plan development and update will be conducted. Special focus will be placed on care planning for i.v. fluid administration, i.v. lines and care of the i.v. site.

Monitoring:

The Director of Nursing or designee will conduct medical records audits of i.v. orders to ascertain if appropriate care plan is in place. This will be conducted daily X 2 weeks then if no issues are identified, weekly X 10. Findings will be reported to the QAPI Committee and further actions taken as appropriate.

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interview and clinical record review, the facility staff failed to develop a comprehensive care plan for one of 19 residents in the survey sample. Resident #4 had no care plan developed regarding care for her intravenous (IV) access site and daily administration of IV fluids.

The findings include:

Resident #4 was admitted to the facility on 9/24/16 with a re-admission on 11/18/16. Diagnoses for Resident #4 included Parkinson's disease, chronic dehydration, Crohn's disease, urinary tract infection and left femur fracture. The minimum data set (MDS) dated 12/16/16 assessed Resident #4 as cognitively intact.

On 3/15/17 at 8:05 a.m. Resident #4 was observed in bed. Intravenous fluid was being administered at 125 milliliters (ml) per hour through an IV access port in the resident's left upper chest. Resident #4 was interviewed at this time about the IV fluids. Resident #4 stated she had ongoing issues with dehydration due to her history of Crohn's disease and she was administered a bag of IV fluids each day to prevent dehydration.

Resident #4's clinical record documented a physician's order dated 12/26/16 for one liter of Sodium Chloride 0.9% solution to be administered intravenously over 8 hours each day for treatment of chronic dehydration. The record also documented physician orders dated 12/26/16 to flush the resident's IV "mid-line" access site with 10 ml of normal saline each day and dressing changes to the access site each week.

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F 279	Continued From page 9 The resident's plan of care (revised 3/1/17) included no problems, goals and/or interventions regarding the resident's IV "mid-line" access site or the daily IV fluid administration. On 3/15/17 at 9:45 a.m. the registered nurse (RN #2) responsible for care plan development was interviewed about Resident #4's IV fluids and IV access site. After reviewing the resident's care plan, RN #2 stated she did not see anything on the care plan about the IV site or IV fluid administration. These findings were reviewed with the administrator and director of nursing during a meeting on 3/15/17 at 4:00 p.m.			
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to follow interventions on a comprehensive care plan (CCP) for one of 19 residents in the survey sample, Resident #6. Facility staff failed to place bilateral palm guards into Resident #6's hands as included in the CCP. Findings included:	F 282	**Corrective Measure for Residents Affected** Resident # 6 was screened by Occupational Therapy staff on 3/16/2017 and the resident no longer needs the palm guards. The physician has discontinued the order for their use and her care plan was updated to reflect this. **Identification of Other Residents with Potential To Be Affected** Other residents with potential to be affected by nursing staff's non-compliance with physician-ordered palm guards were identified through review of physician orders on 3/22. There were two with orders and observation indicated the palm guards are in use. **Measures to Prevent Recurrence** In-service to nursing staff will be conducted to reiterate compliance with physician-ordered or care plan-directed interventions for pressure ulcer prevention. Focus will be on the proper use of palm guards, Prevalon boots, and off-loading of heels. **Monitoring:**	

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Resident #6 was originally admitted to the facility on 01/31/2006 and readmitted on 12/15/2011 with diagnoses including, but not limited to: Stroke, Diabetes, Hypertension, Glaucoma, Seizures, Dysphagia, Feeding (PEG) Tube and Contractures.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/22/2016. Resident #6 was assessed as severely impaired in her short and long term memory and cognitive skills.

Resident #6's medical record was reviewed on 03/15/2017. The CCP for Self Care Deficit included an intervention dated 11/09/16 that stated, "...Bilateral palm guards at all times except during bathing and dressing and hygiene care..."

Resident #6 was observed in her room at 7:45 a.m. and again at 11:00 a.m. Bilateral palm guards were not in place during either observation.

CNA #2 (certified nursing assistant) was interviewed at approximately 11:02 a.m. regarding Resident #6's palm guards. CNA #2 stated, "Yes, no, wait a minute. No she doesn't use those. All she has are these (CNA #2 gestured to Resident #6's bilateral geri sleeves) and they cover part of her palms."

At approximately 11:10 a.m. LPN #2 (licensed practical nurse) was interviewed regarding Resident #6's palm guards. LPN #2 stated, "No, I don't think she uses those. Let me look. (Gestured to the computer). Here it is on the

Monitoring:

The Director of Nursing or designee will conduct inspections to ascertain compliance with use of palm guards, prevalon boots and off-loading of heels. Audits will be conducted daily X 10 then weekly X 10. Findings of these audits will be reported to the QAPI Committee and further actions taken as appropriate.

Correction Date: 4/15/2017

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orders, but it is an OT (occupational therapy) order. It doesn't show up anywhere else. That is why it's not on the TAR (treatment administration sheet) for us to sign off. The original order was written 2/19/16. When therapy stopped she should have been referred to restorative and then to us (meaning nursing). I will have to call the family and then get an OT order for an evaluation. We can't just throw palm guards in there if she hasn't been using them."

LPN #2, CNA #2 and this surveyor went to Resident #6's room. LPN #2 stated, "Here are her palm guards in the drawer." The palm guards were located in the drawer of the nightstand. LPN #2, CNA #2 and this surveyor observed Resident #6's palms. No breakdown was noted on either hand.

The Administrator and DON (director of nursing) were informed of the above during a meeting with survey team on 03/15/17 at 4:00 p.m. No further information was received prior to the exit conference on 03/16/17.

F 309 SS=D 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25 Quality of care

F 309 Provide Care/Services for Highest Well Being

Corrective Measure for Residents Affected

Resident # 12's CPAP mask and nebulizer mask were placed in a plastic bag as soon as surveyor finding was known. He was discharged home on 3/21/17 and further action is not necessary.

Identification of Other Residents With Potential To Be Affected

Other residents with potential to be affected were identified through review of orders on

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F 309	Continued From page 12 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview, and resident interview, the facility staff failed, for one of 19 residents in the survey sample (Resident # 12), to follow physician's orders. The facility staff failed to store Resident # 12's oxygen items in a zip lock bag as ordered by the physician. The findings were: Resident # 12 in the survey sample, an 80 year-old male, was admitted to the facility on 2/20/17 with diagnoses that included atrial fibrillation, coronary artery disease, congestive		3/21/2017 for CPAP/BIPAP and Nebulizer treatments. Their nebulizer or CPAP/BIPAP masks are being stored in plastic bags when not in use. They will be monitored to ensure continued compliance. **Measures To Prevent Recurrence** In-services to nursing staff regarding the facility's infection control policies will be conducted. Compliance with facility policy for storing CPAP/BIPAP and nebulizer masks will be reiterated. Residents who are using respiratory masks and/or their family member/responsible party will also be educated on the proper storage of these devices. **Monitoring:** The DON or designee will perform rounds to ascertain compliance with storage of CPAP/BPAP and nebulizer masks. This will be conducted daily X 2 weeks, then if compliance is maintained, weekly X 10. Findings will be reported to QAPI and further actions taken as appropriate. **Correction Date:** 4/15/2017	

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heart failure, hypertension, gastroesophageal reflux disease, diabetes mellitus, hyperlipidemia, anxiety disorder, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, cataracts, dyspnea, and secondary pulmonary hypertension. According to the Admission Minimum Data Set with an Assessment Reference Date of 2/27/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 13 out of 15.

During the orientation tour at 6:30 p.m. on 3/14/17, Resident # 12 was observed in his room, seated in a wheelchair. After obtaining permission to enter the room, the surveyor noticed a nebulizer mask on top of the night stand located next to the resident's bed. Asked if he used a nebulizer, Resident # 12 replied that he did, and he also stated that he used a C-PAP.

When asked where the C-PAP mask was stored, Resident # 12 said it was in the second drawer of the night stand. After obtaining permission from the resident, the surveyor opened the drawer and observed the C-PAP mask in the drawer. Resident # 12 said the C-PAP mask was his personal mask that he brought from home.

Neither the nebulizer mask nor the C-PAP mask were stored in protective bags.

During the orientation tour, LPN # 4 (Licensed Practical Nurse) was asked how nebulizer masks and C-PAP masks should be stored. "They should be in bags," LPN # 4 said.

Further review of Resident # 12's clinical record revealed the following physician's orders, dated

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2/20/17:

"Auto C-PAP when asleep."
"Oxygen: store oxygen items in a zip lock bag each shift at Shift 1, Shift 2, Shift 3."

The failure to store Resident # 12's nebulizer mask and C-PAP mask in bags was discussed during a meeting at 4:30 p.m. on 3/15/17 that included the Administrator, Director of Nursing, and the survey team.

F 314 SS=E 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

(b) Skin Integrity -

(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-

(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and

(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, the facility staff failed to accurately assess and/or implement interventions for the prevention of pressure ulcers for four of 19 residents in the survey sample.

F 314

Corrective Measure for Residents Affected

The attending physician of Resident # 4 was notified of the healed pressure ulcer on her sacrum and the mepilex dressing was discontinued on 3/15/17. The inaccurate weekly skin assessment cannot be corrected as the open areas have healed. Staff will ensure going forward that this resident's weekly skin assessments are accurate.

Resident # 6 was screened by Occupational Therapy staff and the resident no longer needs the palm guards. The physician has discontinued the order for their use.

Prevalon boots were applied on Resident # 7 during survey. Staff involved in her care has been made aware of this intervention and compliance is being monitored by the clinical coordinators/charge nurses.

Resident # 10 was re-evaluated and is non-compliant with elevating his heels. An order for Prevalon boots was obtained on 3/23/17.

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1. Resident #4 had pressure sore treatments/dressing changes to her sacrum continued for over a month after the pressure sore was assessed as healed without a physician's order to continue the treatment. Resident #4's weekly skin assessments inaccurately listed the resident's skin as "intact" when the resident was being treated for a sacral pressure sore and an open skin area behind her left ear.

2. Resident #6 did not have physician ordered palm guards in use for pressure ulcer prevention.

3. Resident #7 did not have physician ordered Prevalon boots in use for pressure ulcer prevention.

4. Resident #10's heels were not elevated as required in the plan of care for the pressure ulcer prevention.

The findings include:

1a) Resident #4 had pressure ulcer treatments/dressing changes continued for over a month after the pressure sore was assessed as healed without a physician's order to continue the treatment.

Resident #4 was admitted to the facility on 9/24/16 with a re-admission on 11/18/16. Diagnoses for Resident #4 included Parkinson's disease, chronic dehydration, Crohn's disease, urinary tract infection and left femur fracture. The minimum data set (MDS) dated 12/16/16 assessed Resident #4 as cognitively intact.

Identification of Other Residents with Potential To Be Affected

Based on review of weekly Wound Report and medical records on 3/24/17, there were no other current residents affected by nurses' failure to notify the physician of a healed pressure ulcer.

Review of physician orders on 3/22 identified two current residents with orders for palm guard. Observations indicated that they are still appropriate and they are being used.

Review of physician orders on 3/22 identified several current residents with orders for Prevalon boots and observations indicated that they are in use. The same review also indicated several residents with orders for elevating heels. Further review of the need or effectiveness of these interventions will be conducted and actions taken as appropriate.

Other residents affected by the inaccuracy in weekly skin assessments will be identified through review of physician-ordered treatments and weekly skin assessments. Discrepancies will be addressed.

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Resident #4's clinical record documented a re-admission nursing assessment dated 11/18/16 assessing the resident with a stage 2 pressure sore on her sacrum measuring 5 cm x 3 cm x 0 cm (length by width by depth in centimeters). A physician's order dated 11/18/16 stated, "Clean sacrum with normal saline, pat dry, apply Mepilex" with instructions to change the dressing every 3 days. Resident #4's treatment records documented dressing changes to the sacral pressure sore every three days as ordered. A nursing note dated 1/25/17 documented the sacral pressure sore was healed. A wound assessment record dated 1/25/17 also listed the stage 2 pressure sore as "resolved."

Resident #4's physician was not notified the sacrum pressure sore was healed. Treatment records documented continued treatment with the ordered Mepilex dressing every three days to the resident's sacral area from 1/25/17 through 3/12/17 even though the pressure sore was resolved. Nursing notes documented no notification to the physician regarding the change in the status of the resident's pressure sore. There was no physician's order obtained to continue treatment of the sacral area with the Mepilex dressing.

Resident #4's care plan (revised 3/1/17) listed the resident had potential for altered skin integrity. Interventions to prevent skin breakdown included, "Monitor skin condition q [each] shift...If any changes notify MD and treat as soon as possible..."

On 3/15/17 at 11:20 a.m. the licensed practical nurse (LPN #1) responsible for wound treatments

Measures to Prevent Recurrence

In-service to licensed nurses will be conducted to reiterate the facility's policy for notifying the physician of changes in resident condition. Licensed nurses and C.N.A.'s will be in-serviced on pressure ulcer prevention strategies, and compliance with physician-ordered pressure ulcer prevention devices. The Weekly Skin Assessment form will also be reviewed with licensed nurses with focus on accuracy of skin assessments and documentation.

Monitoring:

The Director of Nursing or designee will review the Weekly Wound Report and resident medical record to ascertain if physician has been notified of healing or changes in residents' wounds. Audits will be conducted weekly X 4 then monthly X 2.

The Director of Nursing or designee will review weekly skin assessments for accuracy. Audits will be conducted weekly X 4 then monthly X 2.

The Director of Nursing or designee will conduct rounds to ascertain compliance with use of palm guards, Prevalon boots and elevating of heels. Audits will be conducted daily X 10 then

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was interviewed about Resident #4's sacral pressure ulcer. LPN #1 stated the resident's pressure ulcer healed on 1/25/17. LPN #1 stated she decided to continue the Mepilex dressings as a protective measure. LPN #1 stated she found that sometimes after a pressure ulcer healed the area was tender and had the potential to open back up. When asked if the physician was notified the open pressure ulcer had healed, LPN #1 stated, "I don't see a note notifying the doctor." LPN #1 stated there was no new order received to continue treatment to the resident's sacrum after the sore was resolved. When asked why the physician was not contacted about desired treatment options after the wound had healed, LPN #1 stated, "They give us leeway with that."

On 3/15/17 at 1:20 p.m. LPN #5 caring for Resident #4 was interviewed about ongoing dressing changes to the resident's sacrum. LPN #5 stated the resident's sacral skin was "clear" now and the Mepilex dressing changes were still done to prevent further pressure sores.

On 3/15/17 at 1:35 p.m. an assessment of Resident #4's skin was conducted by LPN #5 and registered nurse (RN) #3. The resident's sacral area had a Mepilex dressing in place at the time of the observation dated 3/12/16. LPN #5 removed the dressing. The resident's sacral area had no redness, no open areas and no signs of skin irritation or breakdown.

On 3/15/17 at 1:50 p.m. the director of nursing (DON) was interviewed about Resident #4's continued treatment after the pressure sore was assessed as healed. The DON stated there should have been notification to the physician about the healed pressure ulcer so orders could

weekly X 10.

Findings of these audits will be reported to the QAPI Committee and further actions taken as appropriate.

Correction Date: 4/15/2017

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be obtained to continue, discontinue or change treatment to the area.

The National Pressure Ulcer Advisory Panel (NPUAP) defines a pressure ulcer/sore as "localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear..." This reference defines a stage 2 pressure sore as, "Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present..." (1)

The manufacturer's information insert described Mepilex as a patented adhesive dressing "designed for a wide range of exuding wounds such as pressure ulcers, leg and foot ulcers and traumatic wounds." (2)

These findings were reviewed with the administrator and director of nursing during a meeting on 3/15/17 at 4:00 p.m.

1b) Resident #4's weekly skin assessments inaccurately listed the resident's skin as "intact" when the resident was being treated for a sacral pressure sore and an open skin area behind her left ear.

Resident #4's clinical record documented a re-admission nursing assessment dated 11/18/16 assessing the resident with a stage 2 pressure

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sore on her sacrum measuring 5 cm x 3 cm x 0 cm (length by width by depth in centimeters). A physician's order dated 11/18/16 stated, "Clean sacrum with normal saline, pat dry, apply Mepilex" with instructions to change the dressing every 3 days. Follow up assessment records were documented for the sacral pressure sore dated 2/9/16, 12/12/16, 12/21/16, 12/28/16, 1/4/17, 1/9/17, 1/18/17 and 1/25/17. The wound record dated 1/25/17 listed the pressure sore as "resolved." A nursing note dated 3/1/17 documented the resident was assessed with an open skin area behind her left ear. This note stated, "...I found an area that was red and swollen and what looked to be a scab...At this moment resident had picked off the scab and now it was an open area with very slight bleeding noted..." A physician's order dated 3/1/17 required bacitracin to be applied to the open skin area twice per day until healed. Treatment records documented the bacitracin was applied as ordered.

Weekly skin integrity sheets for Resident #4 were documented starting on 12/20/16. The weekly skin integrity sheets inaccurately listed the resident's skin as "intact" on sheets dated 12/20/16, 1/5/17 and 1/23/17. These sheets made no mention of the stage 2 pressure sore present on the resident's sacrum. Body diagrams on the forms were blank. Weekly skin integrity sheets dated 3/6/17 and 3/13/17 documented the resident's skin was "intact" and made no mention of the open skin area behind the resident's left ear. Body diagrams on these forms were also blank.

On 3/15/17 at 11:20 a.m. the licensed practical nurse (LPN #1) responsible for wound treatments

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was interviewed about the accuracy of the weekly skin integrity sheets. LPN #1 stated the weekly skin assessment sheets were started during December 2016. LPN #1 stated resident's sacral pressure sore was presented from 11/18/16 until 1/25/17 when the sore was assessed as healed. LPN #1 did not know why the weekly skin integrity sheets did not reflect the pressure sore. LPN #1 stated she routinely completed the wound tracking records and the floor nurses were responsible for completing the weekly skin checks. LPN #1 stated the floor nurses may not have been reviewing the entire body or including the current open areas on the weekly skin sheets.

On 3/15/71 at 1:30 p.m. the registered nurse clinical coordinator (RN #3) was interviewed about the weekly skin assessment sheets. RN #3 stated the skin integrity sheets were supposed to be done weekly by the floor nurses. RN#3 stated Resident #4's skin assessment was scheduled for each Monday evening. RN #3 stated assessments were supposed to include an assessment of all areas of the resident's skin. When asked why the sacral pressure sore was not indicated on the weekly skin sheets dated 12/20/16, 1/5/17 and 1/23/17, RN #3 stated, "I don't know. Maybe they [nurses] were not looking at her sacrum." RN #3 stated she thought the nurses should be looking at the entire body when doing skin assessments and any open areas should be indicated on the form.

On 3/15/17 at 1:35 p.m. an assessment of Resident #4's skin was conducted by LPN #5 and registered nurse (RN) #3. The resident's sacral area had a Mepilex dressing in place dated 3/12/16. LPN #5 removed the dressing. The resident's sacral area had no redness, no open

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areas and no signs of skin irritation or breakdown. A small circular open skin area was present behind the resident's left ear. The open area was approximately 1/4 inch in diameter. The open area had red/pink tissue in the wound bed with no redness, drainage or signs of infection.

On 3/15/17 at 1:50 p.m. the director of nursing (DON) was interviewed about the inaccurate skin assessments for Resident #4. The DON stated prior to December 2016 there was not a formal system for documenting routine skin assessments. The DON stated in December 2016 they started weekly skin assessment sheets. The DON stated the direct care nurses were responsible for performing assessments and reporting any open areas to the wound nurse for ongoing treatment and monitoring. The DON stated the weekly skin assessment should reflect any open skin areas present on the body. The DON stated she recognized there were ongoing issues with getting the assessments done accurately and timely.

These findings were reviewed with the administrator and DON during a meeting on 3/15/17 at 4:00 p.m.

(1) NPUAP Pressure Injury Stages. 2016. National Pressure Ulcer Advisory Panel. 3/17/17. www.npuap.org/
(2) Mepilex Border Sacrum. Molnlycke Health Care. Goteborg, Sweden. 2014.

2. Resident #7 was observed without physician

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ordered Prevalon booties (device for the feet to prevent pressure areas) applied.

Resident # 7 was admitted to the facility 8/8/06 with a readmission date of 10/5/16. Diagnoses for Resident # 7 included, but was not limited to: muscle weakness, high blood pressure, heart disease, and pneumonia.

The most recent MDS (minimum data set) was a quarterly review dated 1/4/17. Resident # 7 was coded as having short term and long term memory problems, and severe impairment in daily decision making skills.

On 3/15/17 at 9:00 a.m. Resident # 7 was observed laying in bed with her eyes closed. Resident # 7 did not have any devices applied to the feet.

The clinical record was reviewed at 9:15 a.m. The current POS (physician order summary) included an order carried forward from 10/5/16 for "Prevalon booties at all times." Resident # 7 was identified as being at risk for pressure areas to the feet and ankle/lower leg area due to her contracted position. Resident # 7 was observed several times throughout the morning without the Prevalon booties on the feet.

On 3/15/16 at 11:00 a.m. CNA (certified nursing assistant) # 1 was asked about the booties for Resident # 7. The facility wound nurse, identified as LPN (licensed practical nurse) # 1 was also present. CNA # 1 stated she did not know where the resident's booties were, but would check to see where they may be. A few moments later CNA # 1 returned to this surveyor with new booties and proceeded to open them from the

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plastic wrap; as she was unwrapping the booties she stated "I think hers may have gone to laundry." LPN # 1 stated "Yes, sometimes when the go to laundry it takes a week to get them back." This surveyor then asked LPN # 1 if Resident # 7 had been without the booties for a week. LPN # 1 quickly stated "Oh, I don't know; I guess she had them on." LPN # 1 was then asked since she changed Resident # 7's dressing daily, if she had observed the resident without the booties on. LPN # 1 stated she did all the wound care for the facility, and really did not remember.

On 3/15/17 at 2:30 p.m. during observation of Resident # 7's dressing change with LPN # 1 and CNA # 1, the booties were observed applied to the feet as ordered. This surveyor commented on the booties, and LPN # 1 stated "Yes; I had to open new booties for her (Resident # 7) last week also. I guess we need to find out what happens when they go to the laundry."

On 3/15/17 at 4:00 p.m. during an end of the day meeting with facility staff the administrator , DON (director of nursing), and vice president of operations were made aware of the above findings. The administrator stated "Some laundry goes over to the hospital, and some laundry is done here in house. We will find out why it's taking so long to get the booties back; they are rather costly."

No further information was provided prior to the exit conference.

3. Facility staff failed to place bilateral palm

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guards into Resident #6's hands per physician order.

Resident #6 was originally admitted to the facility on 01/31/2006 and readmitted on 12/15/2011 with diagnoses including, but not limited to: Stroke, Diabetes, Hypertension, Glaucoma, Seizures, Dysphagia, Feeding (PEG) Tube and Contractures.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/22/2016. Resident #6 was assessed as severely impaired in her short and long term memory and cognitive skills.

Resident #6's medical record was reviewed on 03/15/2017. The current POS (physician order sheet) dated March 2017 included an order dated 02/19/16 that stated, "...OT (occupational therapy) - Patient to wear bilateral palm guards at all times except during bathing and dressing in order to decrease risk for contracture/skin breakdown..."

Resident #6 was observed in her room at 7:45 a.m. and again at 11:00 a.m. Bilateral palm guards were not in place during either observation.

CNA #2 (certified nursing assistant) was interviewed at approximately 11:02 a.m. regarding Resident #6's palm guards. CNA #2 stated, "Yes, no, wait a minute. No she doesn't use those. All she has are these (CNA #2 gestured to Resident #6's bilateral geri sleeves) and they cover part of her palms."

At approximately 11:10 a.m. LPN #2 (licensed

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practical nurse) was interviewed regarding Resident #6's palm guards. LPN #2 stated, "No, I don't think she uses those. Let me look. (Gestured to the computer). Here it is on the orders, but it is an OT (occupational therapy) order. It doesn't show up anywhere else. That is why it's not on the TAR (treatment administration sheet) for us to sign off. The original order was written 2/19/16. When therapy stopped she should have been referred to restorative and then to us (meaning nursing). I will have to call the family and then get an OT order for an evaluation. We can't just throw palm guards in there if she hasn't been using them."

LPN #2, CNA #2 and this surveyor went to Resident #6's room. LPN #2 stated, "Here are her palm guards in the drawer." The palm guards were located in the drawer of the nightstand. LPN #2, CNA #2 and this surveyor observed Resident #6's palms. No breakdown was noted on either hand.

The Administrator and DON (director of nursing) were informed of the above during a meeting with survey team on 03/15/17 at 4:00 p.m. No further information was received prior to the exit conference on 03/16/17.

4. Facility staff failed to float Resident #10's heels while in bed as ordered by the physician.

Resident #10 was admitted to the facility on 03/07/17 with diagnoses including, but not limited to: Right hip fracture with repair, Chronic kidney disease, Cardiomyopathy, Alzheimer's disease and hypertension.

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F 314	Continued From page 26 The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 03/14/17. Resident #10 was assessed as moderately impaired in his cognitive status with a total cognitive score of 08 out of 15. Resident #10's medical record was reviewed on 03/15/17. The current POS (physician order sheet) dated 3/1/2017 through 3/31/17 included an order dated 03/07/17 that stated, "...Misc (miscellaneous) - Float heels while in bed prn (as needed) and check every shift for placement..." Resident #10 was observed on 03/15/17 at 7:40 a.m. and again at 11:00 a.m. lying in bed without his heels floated off the mattress. At approximately 11:04 a.m. LPN #3 (licensed practical nurse) was interviewed regarding floating resident's heels. LPN #3 stated, "I don't know, let's check the orders. He's getting ready to get up soon and go to therapy. Here it is, (gestured to the computer screen). His heels are supposed to be floating when in bed." LPN #3 was interviewed a second time at 3:00 p.m. regarding her interpretation of the physician order as stated above. LPN #3 stated, "I take it to mean float heels when in bed (and) prn. It needs to be clarified because it really doesn't specify and, or, or whatever." The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 03/15/17 at approximately 4:00 p.m. No further information was received by the survey team prior to the exit conference on 03/16/17.	F 314		
F 318	483.25(c)(2)(3) INCREASE/PREVENT	F 318		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 318 SS=D	Continued From page 27 DECREASE IN RANGE OF MOTION			

(c) Mobility.

(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, facility staff failed to ensure devices were used to increase or prevent a decrease in ROM (range of motion) for one of 19 residents in the survey sample, Resident #6.

Facility staff failed to place physician ordered palm guards into Resident #6's hands.

Findings included:

Resident #6 was originally admitted to the facility on 01/31/2006 and readmitted on 12/15/2011 with diagnoses including, but not limited to: Stroke, Diabetes, Hypertension, Glaucoma, Seizures, Dysphagia, Feeding (PEG) Tube and Contractures.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/22/2016. Resident #6 was assessed as severely impaired in her short and long term memory and cognitive skills.

F 318 Increase or Prevent Decrease in Range of Motion

Corrective Measure for Residents Affected

Resident # 6 was screened by Occupational Therapy on 3/16/17 and the screening indicated she no longer needs the palm guard. An order to discontinue the palm guard was given by the physician on 3/16 and its use was discontinued.

Identification of Other Residents With Potential To Be Affected

Records were reviewed on 3/22/17 to identify other residents with orders for palm guard. Two other residents have palm guard orders and inspection of these residents hands indicated that they are being used as ordered.

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Resident #6's medical record was reviewed on 03/15/2017. The current POS (physician order sheet) dated March 2017 included an order dated 02/19/16 that stated, "...OT (occupational therapy) - Patient to wear bilateral palm guards at all times except during bathing and dressing in order to decrease risk for contracture/skin breakdown..."

Resident #6 was observed in her room at 7:45 a.m. and again at 11:00 a.m. Bilateral palm guards were not in place during either observation.

CNA #2 (certified nursing assistant) was interviewed at approximately 11:02 a.m. regarding Resident #6's palm guards. CNA #2 stated, "Yes, no, wait a minute. No she doesn't use those. All she has are these (CNA #2 gestured to Resident #6's bilateral geri sleeves) and they cover part of her palms."

At approximately 11:10 a.m. LPN #2 (licensed practical nurse) was interviewed regarding Resident #6's palm guards. LPN #2 stated, "No, I don't think she uses those. Let me look. (Gestured to the computer). Here it is on the orders, but it is an OT (occupational therapy) order. It doesn't show up anywhere else. That is why it's not on the TAR (treatment administration sheet) for us to sign off. The original order was written 2/19/16. When therapy stopped she should have been referred to restorative and then to us (meaning nursing). I will have to call the family and then get an OT order for an evaluation. We can't just throw palm guards in there if she hasn't been using them."

Measures To Prevent Recurrence

In-services to nursing staff will be conducted to reiterate compliance with physician orders for devices to increase or prevent decrease in range of motion. The policy for reassessing the patient/resident for continued need for palm guard and other contracture preventive devices will also be included in the in-services.

Monitoring:

The DON or designee will audit physician orders to identify new orders for palm guards and residents with palm guard orders will be observed for compliance. This will be conducted daily X 10 then weekly X 10. Findings will be reported to QAPI Committee and further actions taken as appropriate.

Correction Date: 4/15/2017

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F 318	Continued From page 29 LPN #2, CNA #2 and this surveyor went to Resident #6's room. LPN #2 stated, "Here are her palm guards in the drawer." The palm guards were located in the drawer of the nightstand. LPN #2, CNA #2 and this surveyor observed Resident #6's palms. No breakdown was noted on either hand. The Administrator and DON (director of nursing) were informed of the above during a meeting with survey team on 03/15/17 at 4:00 p.m. No further information was received prior to the exit conference on 03/16/17.	F 318		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.		**F 329 Drug Regimen Is Free from Unnecessary Drugs** **Corrective Measure for Residents Affected** Resident # 12 was discharged on 3/21/17 therefore no corrective action can be taken. **Identification of Other Residents With Potential To Be Affected** Records review was completed on 3/27/17 to identify other residents with medication orders that do not specify dosage to be administered and parameters for administration. Orders were clarified with the physician where necessary.	

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F 329	Continued From page 30 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview the facility staff failed, for one of 19 residents in the survey sample (Resident # 12), to ensure the resident was free of unnecessary medications. Resident # 12 had a physician's order for Clonazepam that included two dose options without an assessment of which option to use. The findings were: Resident # 12 in the survey sample, an 80 year-old male, was admitted to the facility on 2/20/17 with diagnoses that included atrial fibrillation, coronary artery disease, congestive heart failure, hypertension, gastroesophageal reflux disease, diabetes mellitus, hyperlipidemia, anxiety disorder, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, cataracts, dyspnea, and secondary pulmonary hypertension. According to the Admission Minimum Data Set (MDS) with an Assessment		**Measures To Prevent Recurrence** In-services to licensed nursing staff will be conducted to reiterate compliance with facility policy for 24-hour chart check to ensure accuracy of medication orders. Focus will be given on the need to obtain physician clarification when orders are ambiguous. Pharmacy director has directed pharmacy staff not to fill medication orders when they involve a dosage range without defining parameters. **Monitoring:** The DON or designee will audit physician orders to identify medication orders with two-dose options. This will be conducted daily X 2 weeks, then weekly X 10. Findings will be reported to QAPI Committee and further actions taken as appropriate. **Correction Date:** 4/15/2017	

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Reference Date (ARD) of 2/27/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 13 out of 15.

Resident # 12 had the following physician's order, dated 2/20/17:

"Clonazepam 1 mg (milligram) tablet. Oral at bedtime at 2100 (9:00 p.m.). Give 1/2 tablet (0.5 mg) to 1 tablet (1 mg) for sleep. Anxiety disorder, unspecified for Insomnia."

(NOTE: Clonazepam is an anticonvulsant with an unlabeled use for anxiety and insomnia. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 276.)

Review of the Electronic Medication Administration Record (E-MAR) for the month of February 2017, and March 2017 as of the 3/15/17, the date of record review, revealed Resident # 12 received Clonazepam as ordered. There was no documentation on the E-MAR for February or March indicating which dose of Clonazepam was administered.

Further review of Resident # 12's clinical record failed to reveal any assessment mechanism for determining under what circumstances the resident was to be administered a half tablet or a whole tablet of Clonazepam

At 10:00 a.m. on 3/16/17, during a meeting with the Administrator, Director of Nursing (DON), and the survey team, the resident's Clonazepam order was discussed. When asked how nursing staff administering the Clonazepam know whether to administer a 1/2 tablet or a whole tablet, the DON

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F 329	Continued From page 32 said, "It needs to be one or the other." The DON went on to indicate the dose administered was up to the nurse giving the Clonazepam.	F 329		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's 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 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 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.		**F 334 Influenza and Pneumococcal Vaccine** **Corrective Measure for Residents Affected** Resident # 4 was administered a pneumococcal vaccination on 3/15/17 pursuant to her request and physician order. **Identification of Other Residents With Potential To Be Affected** Records were reviewed on 3/24/17 to identify other residents who may not have been offered the vaccine. Those who have no documentation to indicate the vaccine was offered or administered will be offered the vaccine. **Measures To Prevent Recurrence** In-service to licensed nursing staff will be conducted to review the facility's pneumococcal vaccination policy. In-service will reinforce completion of Admission Nursing Evaluation.	

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F 334	Continued From page 33 (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's 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 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 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. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to offer a pneumococcal immunization for one of 19 residents in the survey sample. Resident #19 had not been offered the pneumococcal vaccine since her admission to the facility on 9/24/16.	F 334	Compliance with 24-hr review of admission assessments by the clinical coordinators will be reinforced. **Monitoring:** The DON or designee will audit the Admission Nursing Evaluation forms and/or transfer documents of newly admitted patients to identify those who may not have been offered pneumococcal vaccination upon admission. This will be conducted weekly X 4 weeks then monthly X 2. Findings will be reported to QAPI Committee and further actions taken as appropriate. **Correction Date:** 4/15/2017	

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Resident #4's clinical record had no documentation of the resident's pneumococcal immunization status or of any education to the resident about the benefits and potential side effects of the vaccine.

The findings include:

Resident #4 was admitted to the facility on 9/24/16 with a re-admission on 11/18/16. Diagnoses for Resident #4 included Parkinson's disease, chronic dehydration, Crohn's disease, urinary tract infection and left femur fracture. The minimum data set (MDS) dated 12/16/16 assessed Resident #4 as cognitively intact.

Resident #4's clinical record was reviewed on 3/15/16. The record had no documentation of the resident's pneumococcal immunization status or of any education to the resident about the benefits and potential side effects of the vaccine. A resident immunization/screening record for Resident #4 had no entries indicating a date and/or refusal for the pneumococcal vaccine. The record documented no consent or refusal form signed by the resident concerning the pneumococcal immunization.

This finding was reviewed with the administrator and director of nursing on 3/15/17 at 4:00 p.m. Any information about the resident's pneumococcal immunization status was requested at this time.

On 3/16/17 at 9:40 a.m. the administrator stated Resident #4 had not been administered the pneumococcal vaccine until last night (3/15/17). The registered nurse clinical coordinator (RN #4) stated she did not know why Resident #4 had not

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COMMUNITY MEMORIAL	125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970

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F 334	Continued From page 35	F 334		

been offered the vaccine. RN #4 stated, "We asked her [Resident #4] last night and she consented." On 3/16/17 at 9:45 a.m. the director of nursing (DON) was interviewed about Resident #4's pneumococcal vaccine status. The DON stated all residents were supposed to be screened upon admission and offered the influenza and pneumococcal vaccine. The DON stated a vaccine history was supposed to be obtained upon admission. The DON stated there was no consent form obtained from Resident #4 concerning the pneumococcal vaccine. The DON stated, "We asked her [Resident #4] yesterday [3/15/17] and she gave us consent." The DON stated the resident had not been offered the pneumococcal vaccine prior to last night (3/15/17).

The facility's policy titled Influenza and Pneumococcal Vaccination for Patients (revised 9/24/12) stated the purpose of the policy was to ensure patients received influenza and pneumococcal vaccinations consistent with evidence-based guidelines and applicable laws and regulations. The policy stated, "All inpatients and observation status patients...are screened for influenza and/or pneumococcal vaccination...Prior to being vaccinated, all patients, or their surrogate decision maker, received the Vaccine Information Statements (VIS) providing education regarding the benefits, risks and potential side effects of the influenza and/or pneumococcal vaccine...Documentation of the patient's immunization status, relative to influenza and pneumococcal vaccinations, is maintained in the patient's medical record...Nursing completes the influenza and pneumococcal vaccine screening as part of the inpatient admission assessment within 24 hours of admission..."

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F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS			

(a) Infection prevention and control program.

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism

F 441 Infection Control

Corrective Measure for Residents Affected

Resident # 8"s CPAP mask was placed in a bag as soon as surveyor finding was known. She will be monitored to ensure staff compliance.

Resident # 12's CPAP mask and nebulizer mask were placed in a bag as soon as surveyor finding was known. He was discharged home on 3/21/17 and further action is not necessary.

Identification of Other Residents with Potential To Be Affected

Other residents with potential to be affected by nursing staff's non-compliance with proper storage of respiratory masks were identified through review of physician orders on 3/21/17 and corrective measures were taken as appropriate.

Measures to Prevent Recurrence

In-service to nursing staff will be conducted to reiterate compliance with facility's policy for storage of respiratory masks.

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F 441	Continued From page 37 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, resident interview, and staff interview, the facility staff failed, for two of 19 residents in the survey sample (Residents # 8 and 12), to protect respiratory devices in a manner that would prevent possible contamination. Resident # 8 had a C-PAP mask, and Resident # 12 had a nebulizer mask and a C-PAP mask that was not stored in a protective bag. The findings include:	F 441	Residents who are using respiratory masks and/or their family member/responsible party will also be educated on the proper storage of these devices. **Monitoring:** The Director of Nursing or designee will conduct inspections to ascertain compliance with proper storage of respiratory masks. Audits will be conducted daily X 10 then if substantial compliance is maintained, weekly X 10. Findings of these audits will be reported to the QAPI Committee and further actions taken as appropriate. **Correction Date:** 4/15/2017	

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F 441	Continued From page 38	F 441		

1. Resident # 12's nebulizer mask and C-PAP mask were not stored in a protective bag.

Resident # 12 in the survey sample, an 80 year-old male, was admitted to the facility on 2/20/17 with diagnoses that included atrial fibrillation, coronary artery disease, congestive heart failure, hypertension, gastroesophageal reflux disease, diabetes mellitus, hyperlipidemia, anxiety disorder, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, cataracts, dyspnea, and secondary pulmonary hypertension. According to the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/27/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 13 out of 15.

During the orientation tour at 6:30 p.m. on 3/14/17, Resident # 12 was observed in his room, seated in a wheelchair. After obtaining permission to enter the room, the surveyor noticed a nebulizer mask on top of the night stand located next to the resident's bed. Asked if he used a nebulizer, Resident # 12 replied that he did, and he also stated that he used a C-PAP.

When asked where the C-PAP mask was stored, Resident # 12 said it was in the second drawer of the night stand. After obtaining permission from the resident, the surveyor opened the drawer and observed the C-PAP mask in the drawer. Resident # 12 said the C-PAP mask was his personal mask that he brought from home.

Neither the nebulizer mask nor the C-PAP mask were stored in protective bags.

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During the orientation tour, LPN # 4 (Licensed Practical Nurse) was asked how nebulizer masks and C-PAP masks should be stored. "They should be in bags," LPN # 4 said.

Further review of Resident # 12's clinical record revealed the following physician's orders, dated 2/20/17:

"Auto C-PAP when asleep."
"Oxygen: store oxygen items in a zip lock bag each shift at Shift 1, Shift 2, Shift 3."

At 11:10 a.m. on 3/15/17, the Director of Nursing (DON) was asked if there was a facility policy for the storage of nebulizer masks and C-PAP masks. "There is no policy for storage of breathing treatment (nebulizer) masks and C-PAP masks in a bag. It is a practice," the DON said. "Even in the hospital it is a practice," the DON continued. "That is something we will have to look at."

The Potter-Perry Fundamentals of Nursing notes the following: "Sites for and Causes of Health Care-Associated Infection...Respiratory Tract: Contaminated respiratory therapy equipment."

(Ref. Potter-Perry Fundamentals of Nursing, 7th Edition, 2009, page 648.)

2. Resident # 8 had a C-PAP mask that was not stored in a protective bag.

Resident # 8 in the survey sample, a 53 year-old female, was admitted to the facility on 1/15/14 with diagnoses that included heart failure, history of pneumonia, major depressive disorder, anxiety

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disorder, hypertension, hypothyroidism, dysphagia, generalized muscle weakness, obesity, and chronic kidney disease. According to the most recent Annual MDS with an ARD of 12/5/16, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

During the orientation tour at 5:50 p.m. on 3/14/17, a C-PAP mask was observed on top of the night stand next to the resident's bed. The C-PAP mask was not in a protective bag.

Further review of Resident # 8's clinical record revealed the following physician's order, dated 4/11/14:

"C-PAP therapy with C-PAP titrited per order from Dr. (name) and respiratory to set pressure."

During the orientation tour, LPN # 4 was asked about Resident # 8's use of the C-PAP. "I have been here two years and I have never seen her use it," LPN # 4 said.

Review of the E-TAR (Electronic Treatment Administration Record) for the month of March 2017 revealed that as of 3/15/17, the date of clinical record review, Resident # 8 had not used the C-PAP. On the reverse side of the E-TAR, under the heading "PRN (as needed) Results and Documentation Report," the following notation appeared for the days Resident # 8 did not use the C-PAP, "Held due to res. (resident) refuses."

Review of the E-TAR's for five previous months revealed the Resident # 8's use of the C-PAP as follows:

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F 441	Continued From page 41 For February 2017 - used six out of 28 days For January 2017 - used five out of 31 days For December 2016 - used four out of 31 days For November 2016 - used one out of 30 days For October 2016 - used five out of 31 days In each instance the C-PAP was not used, the notation "Held due to res. refuses" was entered on the "PRN Results and Documentation Report" portion of the E-TAR for that particular month. During a meeting at 10:30 a.m. on 3/16/17 that included the Administrator, DON, and the survey team, Resident # 8's sporadic use of the C-PAP was discussed. "Her doctor knows she doesn't use it," the DON said, "but he wants to keep it just in case she does want it."	F 441		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain-	F 514		

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F 514	Continued From page 42 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility staff failed, for one of 19 residents in the survey sample (Resident # 12), to maintain a complete and accurate clinical record. The facility staff failed to accurately document the dose of Clonazepam administered to Resident # 12. The findings were: Resident # 12 in the survey sample, an 80 year-old male, was admitted to the facility on 2/20/17 with diagnoses that included atrial fibrillation, coronary artery disease, congestive heart failure, hypertension, gastroesophageal reflux disease, diabetes mellitus, hyperlipidemia, anxiety disorder, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, cataracts, dyspnea, and secondary pulmonary hypertension. According to the Admission Minimum Data Set (MDS) with an Assessment		**F 514 Resident Record is Complete/Accurate and Accessible** **Corrective Measure for Residents Affected** Resident # 12 was discharged home on 3/21/17 and no further action can be taken. **Identification of Other Residents with Potential To Be Affected** On 3/27/17, physician orders of current residents were reviewed to identify other residents with medication orders that have a two-dose option and no parameters for which dose to give. Physician clarification will be obtained for residents that were affected. **Measures to Prevent Recurrence** In-service to nursing staff will be conducted to reiterate the need for obtaining clarification from the physician when a medication is ordered with a two-dose option without parameters for choosing which dose to give. Special focus will be on proper transcription onto the MAR for these types of orders.	

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F 514	Continued From page 43 Reference Date (ARD) of 2/27/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 13 out of 15. Resident # 12 had the following physician's order, dated 2/20/17: "Clonazepam 1 mg (milligram) tablet. Oral at bedtime at 2100 (9:00 p.m.). Give 1/2 tablet (0.5 mg) to 1 tablet (1 mg) for sleep. Anxiety disorder, unspecified for Insomnia." (NOTE: Clonazepam is an anticonvulsant with an unlabeled use for anxiety and insomnia. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 276.) Review of the Electronic Medication Administration Record (E-MAR) for the months of February 2017, and March 2017 as of the 3/15/17, the date of record review, revealed Resident # 12 received Clonazepam as ordered. On the reverse side of the E-MAR's for February and March, under the heading "PRN (as needed) Results and Documentation Report," there were no notations to indicate which dose of Clonazepam was administered. At 10:20 a.m. on 3/16/17, LPN # 6 (Licensed Practical Nurse) was interviewed regarding the administration of a half tablet or a whole tablet of Clonazepam to Resident # 12. Advised there was no way to tell which dose was administered by looking at the E-MAR, LPN # 6 said it might be possible to tell by looking at the Diebold System to see which dose was obtained. (NOTE: The Diebold System is an automated system used to access and dispense controlled medications.)	F 514	Pharmacy director has directed pharmacy staff not to fill medication orders when they involve a dosage range without defining parameters. **Monitoring:** The Director of Nursing or designee will conduct audits of physician orders. Audits will be conducted daily X 10 then weekly X 10. Findings of these audits will be reported to the QAPI Committee and further actions taken as appropriate. **Correction Date:** 4/15/2017	

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LPN # 6 took the surveyor to the Medication Room where the Diebold System was located. After several minutes, LPN # 6 was able to access the medication list for Resident # 12. According to the Diebold System, only whole tablets of Clonazepam were available. When asked about administering a half tablet, LPN # 6 said it would take two nurses, one to access the Diebold, obtain the whole tablet and break it in two, and a second nurse to witness the first nurse wasting (throwing away) the half tablet not administered. LPN # 6 went on to say that the nurse obtaining the whole tablet would need to manually enter the obtaining of a half tablet in the Diebold System.

At 10:00 a.m. on 3/16/17, during a meeting with the Administrator, Director of Nursing (DON), and the survey team, the resident's Clonazepam order was discussed. It was pointed out that entries on the E-MAR only noted that Clonazepam was administered, and not which dose.