DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	09/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(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 9/6/17 through 9/8/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 39 bed facility was 29 at the time of the survey. The survey sample consisted of 11 current residents (Residents #1 through #10 and Resident #12); and 1 closed record, (Residents #11).	F 000	F 000 This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Covenant Woods is committed to sustaining compliance with regulations.	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS (c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review it was determined that the facility staff failed to complete a quarterly MDS (minimum data set) assessment for one of 12 residents in the survey sample; Resident #1. The facility staff did not complete a quarterly MDS (Minimum Data Set) assessment for Resident #, that was due in March, 2017. The findings include: Resident #1 was admitted to the facility on 4/30/17 and readmitted on 5/26/17 with the	F 276		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carrie Davis | TITLE: Administrator | (X6) DATE: 9-22-17

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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diagnoses of but not limited to congestive heart failure, atrial fibrillation, dementia, sleep apnea, benign prostatic hypertrophy, high blood pressure, and thrombosis.

The most recent MDS was a quarterly assessment with an ARD (Assessment Reference Date) of 8/14/17. Resident #1 was coded as being severely cognitively impaired in ability to make daily life decisions, scoring a 4 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1was coded as requiring total care for bathing; extensive care for transfers, dressing, and hygiene; as independent for eating; and as usually continent of bowel and as having an indwelling catheter for bladder.

A review of the clinical record revealed Resident #1 had a comprehensive MDS assessment completed with an ARD of 11/18/16; and the next assessment completed was an admission (readmission) with an ARD of 5/22/17. There were no quarterly or comprehensive assessments completed between these dates. At the minimum, a quarterly assessment was due approximately March 2017.

On 9/7/17 at approximately 1:00 p.m., an interview was conducted with RN #3 (Registered Nurse) who was doing MDS assessments at the time of the missed assessment. RN #3 stated the facility had changed computer systems around that time (March) and in the changeover, Resident #1's quarterly assessment was missed. She stated the old system reflected that the MDS pathway had been opened to begin the assessment, but did not carry over when the old MDS system was merged into the new MDS system. When asked what policy the facility uses

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1. Resident #1 was not found to be adversely affected.

2. 100% audit of the most recent comprehensive and quarterly MDS assessment dates for each current resident to ensure assessments have been scheduled and completed per RAI. 9/29/17

3. Will audit the MDS assessment schedule for three residents a week for four weeks. 10/20/17

4. Will provide documentation of weekly audits to the DON for review. 10/20/17

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F 276	Continued From page 2 to complete the MDS assessments, RN #4, the current MDS nurse, stated the RAI manual. On 9/7/17 at approximately 5:30 p.m., the Administrator (administrative staff member [ASM] #1) was made aware of the findings. No further information was provided by the end of the survey. According to the RAI manual (Resident Assessment Instrument), "The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type."	F 276		
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	F 279		

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(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 -

(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

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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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop a comprehensive care plan for two of 12 residents in the survey sample, Resident #2 and Resident #6.

1. The facility staff failed to develop a behavior care plan based on the CAA (care area assessment) trigger in section V. of Resident #2's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 5/2/17.

2. The facility staff failed to develop a vision care plan based on the CAA trigger in section V. of Resident #6's significant change MDS assessment with an ARD of 8/24/17.

The findings include:

1. The facility staff failed to develop a behavior care plan based on the CAA (care area assessment) trigger in section V. of Resident #2's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 5/2/17.

Resident #2 was admitted to the facility on 5/11/12 and readmitted on 4/25/17 with diagnoses that included but were not limited to: high blood

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F 279	Continued From page 5 pressure, stroke, pain, arthritis and respiratory failure. The most recent MDS, a quarterly assessment, with an ARD of 8/2/17 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from facility staff for all activities of daily living except for eating which the resident could do after the meal tray was prepared. The admission MDS assessment with an ARD of 5/2/17 coded the resident in Section E -- Behavior, E0800 -- Rejection of care - Presence & Frequency. Did the resident reject evaluation of care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being?" The resident was coded as a "1" indicating that "Behavior of this type occurred 1 to 3 days." Review of section V. the CAA section of the MDS assessment documented, "09. Behavioral Symptoms. A. Care Area Triggered (an "X" was in the box indicating the area was triggered). B. Care Planning Decision (a "1" was in the box indicating the area was to be care planned)." Review of the Resident #2's comprehensive care plan created on 5/5/17 documented, "Psychosocial, Mood, and Behavior" did not evidence documentation or a plan of care with interventions to address behaviors for Resident #2. An interview was conducted on 9/8/17 at 11:10 a.m. with LPN (licensed practical nurse) #3. When asked why residents had care plans, LPN #3 stated, "So we can know how to take care of	F 279	F 279 1. Resident #2 was not found to be adversely affected. Plan of care for behavior has been updated to reflect what was documented in the behavior CAA.	9/8/17
			2. 100% audit will be performed for all residents' behavior CAAs and compared to behavior care plans. Findings will be reviewed at the interdisciplinary team morning meeting.	9/29/17
			3. After the complete audit has been performed, 3 behavior CAAs will be chosen at random and reviewed weekly by the Social Worker. The behavior CAAs will be compared to the behavior care plans to ensure accuracy. Behavior CAAs will also be reviewed during comprehensive assessments.	10/20/17
			4. An audit spreadsheet will be completed weekly to document when behavior care plans and CAAs are reviewed and the findings. The findings will be reviewed weekly at the interdisciplinary teams morning meeting ton include the DON, Administrator and MDS Coord.	10/20/17

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the resident in an efficient manner." When asked who developed the care plans, LPN #3 stated, "Up here (on the unit) I'm not sure but I think it's the unit manager. I usually work A.L. (assisted living)."

An interview was conducted on 9/8/17 at 11:15 a.m. with RN (registered nurse) #4, the MDS coordinator. When asked who completed the behavior sections of the MDS assessments, RN #4 stated, "Social services generates that one." When asked why a care plan was developed, RN #4 stated, "I develop the care plan so it gives the healthcare worker a guide to what preferences the resident has, what's their medical condition." When asked to review Resident #2's comprehensive care plan for a plan of care for behaviors, RN #4 stated, "I don't see it."

An interview was conducted on 9/8/17 at 11:30 a.m. with OSM (other staff member) #3, the social worker. When asked who developed the care plan for behavior, OSM #3 stated, "I do." When asked why a care plan is developed, OSM #3 stated, "To make sure that the care is tailored to the resident and there needs because everyone is different." OSM #3 was asked to review Resident #2's comprehensive care plan for a plan of care with interventions to address behaviors. OSM #3 stated, "It doesn't have one."

On 9/8/17 at 12:15 a.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled "CARE PLANNING" documented, "Policy: A preliminary plan of care to meet the resident's immediate

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needs shall be developed for each resident within twenty-four (24) hours of admission. An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Procedures: 2) A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident's comprehensive assessment (MDS). 6) Each resident's comprehensive care plan is designed to: a) incorporate identified problem areas; b) Incorporate risk factors associated with identified problems. 7) Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan."

No further information was provided prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1)

(1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

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2. The facility staff failed to develop a vision care plan based on the CAA trigger in section V. of Resident #6's significant change MDS assessment with an ARD of 8/24/17.

Resident #6 was admitted to the facility on 7/1/11 and readmitted on 8/31/17 with diagnoses that included but were not limited to: kidney stones, difficulty urinating, diverticulitis (1) and macular degeneration (2). The most recent MDS, a significant change assessment, with an ARD of 8/24/17 coded the resident as being understood and understanding others. Resident #6 was coded as having an intact long-term and short-term memory. The resident was coded as requiring assistance from staff for all activities of daily living. In section V. CAA the resident was triggered for 3. visual function. It was documented that this was a triggered care area and that a care plan would be developed for visual function.

Review of the physician's orders dated August 2017 documented, "PreserVison AREDS (3) 2...Notes: Instructions: Therapeutic Range: Unspecified MACULAR DEGENERATION. Order Date: 8/25/2016."

Review of the care plan created on 5/23/17 documented, "COGNITION, COMMUNICATION, AND VISION" did not evidence documentation regarding the resident's macular degeneration.

An interview was conducted on 9/8/17 at 11:10 a.m. with LPN (licensed practical nurse) #3. When asked why residents had care plans, LPN #3 stated, "So we can know how to take care of the resident in an efficient manner." When asked

1. Resident #6 was not found to be adversely affected. Plan of care for vision has been updated to reflect what was documented in the vision CAA. — 9/8/17

2. 100% audit will be performed for all residents' vision CAAs and compared to vision care plans. 100% audit of care plans to ensure inclusion of current diagnosis. Findings will be reviewed at the interdisciplinary team morning meeting. — 9/29/17

3. After the complete audit has been performed, 3 vision CAAs will be chosen at random and reviewed weekly by the MDS Coord. The vision CAAs will be compared to the vision care plans to ensure accuracy. Also, during the comprehensive assessment, ensure inclusion of current diagnosis on care plan. — 10/20/17

4. An audit spreadsheet will be completed weekly to document when care plans are reviewed and the findings. The findings will be reviewed weekly at the interdisciplinary teams morning meeting ton include the DON, Administrator and MDS Coord. — 10/20/17

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who developed the care plans, LPN #3 stated, "Up here (on the unit) I'm not sure but I think it's the unit manager. I usually work A.L. (assisted living)."

An interview was conducted on 9/8/17 at 11:15 a.m. with RN (registered nurse) #4 MDS coordinator. When asked who completed the vision section of the MDS assessments, RN #4 stated, "Social services generates that one." When asked why a care plan was developed, RN #4 stated, "I develop the care plan so it gives the healthcare worker a guide to what preferences resident has, what's their medical condition." When asked to review Resident #6's care plan for a plan of care to address Resident #6's visual impairment, RN #4 stated, "I don't see it."

An interview was conducted on 9/8/17 at 11:30 a.m. with OSM (other staff member) #3, the social worker. When asked who developed the care plan for vision, OSM #3 stated, "I do." When asked why a care plan is developed, OSM #4 stated, "To make sure that the care is tailored to the resident and their needs because everyone is different." OSM #4 was asked to review Resident #6's care plan for a plan of care to address Resident #6's visual impairment. OSM #4 stated, "It doesn't have one. I think it was an oversight."

On 9/8/17 at 11:45 a.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

(1) Diverticulitis: Diverticular disease of the colon is among the most prevalent conditions in

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western society and is among the leading reasons for outpatient visits and causes of hospitalization. While previously considered to be a disease primarily affecting the elderly, there is increasing incidence among individuals younger than 40 years of age. Diverticular disease most frequently presents as uncomplicated diverticulitis, and the cornerstone of management is antibiotic therapy and bowel rest. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3174080/

(2) Macular Degeneration: Macular degeneration, or age-related macular degeneration (AMD), is a leading cause of vision loss in Americans 60 and older. It is a disease that destroys your sharp, central vision. You need central vision to see objects clearly and to do tasks such as reading and driving. This information was obtained from: https://medlineplus.gov/maculardegeneration.html

(3) PreserVison AREDS: The Age-Related Eye Disease Study (AREDS) - sponsored by the Federal Government's National Eye Institute - has found that taking high levels of antioxidants and zinc can reduce the risk of developing advanced age-related macular degeneration (AMD) by about 25 percent. This information was obtained from: https://nei.nih.gov/amd/summary

F 328 SS=D 483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS — F 328

(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:

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(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and

(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments

(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the

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COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to administer oxygen as ordered by the physician for one of 12 residents in the survey sample, Resident #6.

The facility staff failed to administer Resident #6's oxygen at two liters per minute as per the physician's order.

The findings include:

- Resident #6 was admitted to the facility on 7/1/11 and readmitted on 8/31/17 with diagnoses that included but were not limited to: kidney stones, difficulty urinating, diverticulitis (1) and macular degeneration (2). The most recent MDS, a significant change assessment, with an ARD of 8/24/17 coded the resident as being understood and understanding others. The resident was coded as having an intact long-term and short-term memory. The resident was coded as requiring assistance from staff for all activities of daily living. In Section O. Special Treatment, Procedures, and Programs. Section O0100 the

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F 328	Continued From page 13 resident was coded as receiving oxygen therapy. Review of the physician's orders dated September 2017 documented, "O2 (oxygen) at 2L (liters)/m (minute) per nasal cannula. Order Date: 9/6/2017. Review of the treatment administration record did not evidence documentation regarding the oxygen order. Review of the care plan created on 5/23/17 and revised on 8/23/17 titled, "Cardiovascular Compromise" documented, "Administer oxygen per order." An observation was made on 9/6/17 at 4:05 p.m. of Resident #6. The resident was sitting up in a wheelchair. The resident was receiving oxygen via a nasal cannula (soft prongs that fit in the nose to deliver oxygen) connected to an oxygen concentrator. The oxygen concentrator flow rate was set at four and 1/4 liters/minute. An observation was made on 9/7/17 at 9:02 a.m. Resident #6 was lying in bed with eyes closed. The resident had a nasal cannula on and the oxygen concentrator flow rate was set at three liters/minute. An observation was made at 11:30 a.m. of Resident #6. The resident was up in a wheelchair with a nasal cannula on. The oxygen concentrator flow rate was set at three liters/minute. An observation was made of Resident #6 on 9/8/17 at 7:51 a.m. The resident was in bed with the nasal cannula on connected to an oxygen concentrator. The oxygen concentrator flow rate	F 328	F 328 1. Resident #6 was not found to be adversely affected. Liter flow was adjusted to deliver oxygen at rate per MD order. Liter flow for all residents receiving oxygen therapy were checked for accuracy per MD order. 9/8/17 2. 100% audit was performed of all resident files for accuracy of MD orders who receive oxygen therapy. 9/11/17 3. Review of nursing procedures for oxygen therapy with nursing staff. 9/27/17 ➢ In-service nursing staff on policy and procedures for oxygen therapy. 4. Unit manager or designee to conduct weekly audits on residents receiving oxygen therapy (weekly for two weeks then every month). 10/20/17	

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was set at three liters/minute.

An observation was made of Resident #6 on 9/8/17 at 10:58 a.m. with RN (registered nurse) #3, the evening shift unit manager. The resident was in bed with the nasal cannula on connected to an oxygen concentrator. RN #3 was asked to check the oxygen flow rate on the oxygen concentrator, RN #3 stated, "It's (the oxygen flow rate) at three and 1/2 liters." When asked what the oxygen flow rate was supposed to be set at, RN #3 stated, "I think it's three liters but I have to check the EMAR (electronic medication administration record)." RN #3 checked Resident #6's EMAR and stated, "It's supposed to be at two liters." RN #3 then returned to the resident's room and adjusted the oxygen flow rate on the oxygen concentrator to the correct rate.

An interview was conducted on 9/8/17 at 11:12 a.m. with LPN (licensed practical nurse) #3, the resident's nurse. When asked the process staff followed to check the resident's oxygen rate, LPN #3 stated, "We're supposed to check it when we go in and give them their meds (medications)." When asked why it was important that the oxygen be set at the physician ordered rate, LPN #3 stated, "It's a med. If you don't get the correct amount you're supposed to get, it could do as much harm as good." When asked what flow rate Resident #6's oxygen should be set at, LPN #3 stated, "I just looked at the MAR (medication administration record) and it's supposed to be at two liters." When asked if she had checked Resident #6's oxygen that morning, LPN #3 stated, "I hadn't checked her oxygen yet. I just checked on her to make sure she was breathing."

An interview was conducted on 9/8/17 at 12:00

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p.m. with RN #3. When asked the process staff followed when a resident was on oxygen, RN #3 stated, "The process is to check it (the oxygen flow rate) when you first come on and then throughout the shift." When asked why it was important that the resident received the oxygen as ordered by the physician, RN #3 stated, "It's a medication."

An interview was conducted on 9/8/17 at 12:10 p.m. with LPN #1, the day shift unit manager. When asked why the oxygen order for two liters/minute for Resident #6 was not on the treatment administration record, LPN #1 stated, "It's the way they entered the oxygen order into the treatment administration record in the software. Since the oxygen is continuous the nurse must sign it the oxygen off at the end of the shift on the treatment administration record. The only way you can see it is to pull up the nurse's sign off section (of the treatment administration record). I know it's confusing." A request was made to see the sign off sheet from the treatment administration record and the sign off sheet was provided. Review of the sign off sheet from the treatment administration record revealed the following was documented, "OXYGEN (O2) AT 2 L/MIN PER NASAL CANNULA. Continuous beginning 9/6/2017."

On 9/8/17 at 12:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Oxygen Administration" documented, "Purpose. The purpose of the procedure is to provide guidelines for safe oxygen administration. Preparation. 1.

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Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration."

No further information was provided prior to exit.

According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."

(1) Diverticulitis: Diverticular disease of the colon is among the most prevalent conditions in western society and is among the leading reasons for outpatient visits and causes of hospitalization. While previously considered to be a disease primarily affecting the elderly, there is increasing incidence among individuals younger than 40 years of age. Diverticular disease most frequently presents as uncomplicated diverticulitis, and the cornerstone of management is antibiotic therapy and bowel rest. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3174080/

(2) Macular Degeneration: Macular degeneration, or age-related macular degeneration (AMD), is a leading cause of vision loss in Americans 60 and older. It is a disease that destroys your sharp, central vision. You need central vision to see objects clearly and to do tasks such as reading

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F 328	Continued From page 17 and driving. This information was obtained from: https://medlineplus.gov/maculardegeneration.html	F 328		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to serve food and store food in a sanitary manner. 1. The facility staff failed to label an opened	F 371		

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F 371	Continued From page 18 gallon container of sesame salad dressing. 2. During the 9/6/17 dinner preparation, the facility staff failed to wear a beard hair protective cover and failed to change their gloves after wiping their nose on the back of their glove. The findings include: 1. An observation of the kitchen was conducted on 9/6/17 at 3:40 p.m. with OSM (other staff member) #6, the dietary manager. In the walk-in refrigerator on the top shelf was a gallon container of sesame salad dressing. There was approximately 3/4's of the salad dressing remaining in the container. There was no open date on the container. There was no manufacturer's use by date on the container only the date it was bottled which was March 2017. An interview was conducted with OSM #6 at that time. When asked why food was marked with the open date, OSM #6 stated so they would know when it was opened and when it would be discarded. Review of the facility's policy titled, "FOOD LABELING AND DATING" documented, "Policy: It is Dining Service Policy that all food, whether raw or prepared, be properly covered, labeled and dated." On 9/7/17 ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. 2. On 9/6/17 at 4:35 p.m., an observation was made of OSM (other staff member) #5, the cook, taking the temperature checks of the food for the resident's dinner service. OSM #5 had a mustache and goatee. OSM #5 was not wearing	F 371	F 371 (1) 1. Open container was disposed of at the time observed. 9/6/17 2. No residents were found to be directly affected. 3. New labels have been ordered with a highlighted area for the discard date so that it is easier to identify. 10/12/17 ➢ All staff will be in-serviced on proper labeling and dating. 10/18/17 4. Management will do random weekly audits over the next 4 weeks. 10/20/17	

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a protective cover over his beard. OSM #5 was observed wiping his nose on the back of his glove and then returned to the food steam table and stirred food. OSM #5 did not change his gloves prior to returning to the food steam table and handling utensils.

An interview was conducted on 9/7/17 at 1:12 p.m. with OSM #6 the dietary manager and OSM #7, the dining room manager. When asked what precautions a staff member with a beard who was preparing food should take, OSM #6 stated, "They should have a beard guard on." When asked when staff should change their gloves, OSM #7 stated, "They change their gloves after they touch anything else than what they're serving." When asked why staff followed these practices, OSM #7 stated, "Because of possible infection. They can cross-contaminate and spread disease." OSM #6 and OSM #7 were made aware of the observations and findings.

An interview was conducted on 9/7/17 at 2:30 p.m. with OSM #5, the cook. When asked what protection staff should wear when preparing and serving food, OSM #5 stated, "This face guard (the staff was wearing a face guard at this time), some kind of hat and protective gloves." When asked why staff wore these items, OSM #5 stated, "For protection of the client." When OSM #5 was made aware of the observation during the 9/6/17 dinner preparation, OSM #5 stated, "I should have removed my gloves, washed my hands and put on new ones (gloves)."

On 9/7/17 at 5:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

1. OSM #5 met with management to review policy and procedures regarding infection control, including handwashing and hair protection. 9/6/17

2. No residents were found to be adversely affected.

3. All staff will be in-serviced on proper hair restraints and infection control including hand washing and proper glove use. 10/18/17

4. Management will do random weekly audits over the next 4 weeks. 10/20/17

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Review of the facility's policy titled, "EMPLOYEE -- HAIR/BEARD" documented, "Policy: Dietary staff must wear hair restrains (e.g. hairnet, hat, and/or beard restraint) to prevent their hair from contacting exposed food, clean equipment, utensils, and lines...Beard guards must be worn if the beard or mustache exceeds a "5 o'clock shadow."

Review of the facility's policy titled, "EMPLOYEE -- GLOVE USE" documented, "Policy: Single use gloves will be used to provide a food safe barrier between hands and food and to prevent cross-contamination. Gloves should never be used in the place of hand washing, and hands must be washed before putting on gloves and when changing to a new pair. Procedure: Food handlers must change gloves: Any time they become contaminated."

Review of the facility's policy titled, "EMPLOYEE -- HANDWASHING" documented, "Policy: Hand washing is the most important part of personal hygiene. Employees are required to use correct hand washing procedures in order to maintain sanitary conditions and prevent the spread of infections. When to wash hands: Dining service employees must wash their hands before they start work. Hands must be washed before putting on gloves, after removing gloves, and after the following activities, 3. Touching the hair, face, or body."

No further information was provided prior to exit.

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

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(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

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F 441	Continued From page 22 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 observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to maintain an infection control program as evidenced by incomplete infection control tracking, trending, and surveillance logs for November 2016, December 2016, and May 2017; and failed to failed to follow infection control practices for 2 of 4 residents in the medication administration observation task; Residents #7 and #8, and; facility staff failed to change gloves or sanitize their hands prior to serving or feeding	F 441	F 441 (1) 1. No residents were found to be adversely affected during review of alternative data available. 9/8/17 2. There is a dedicated staff person assigned to maintain infection control information. ➢ There will be a redundancy in the process for saving infection control documentation. 10/20/17 3. DON or designee will audit documentation for completion monthly. 10/20/17	

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residents during the lunch service on 9/7/17.

1. The facility staff failed to maintain infection control tracking, trending, and surveillance logs for 3 of the last 12 months (November 2016, December 2016, and May 2017.)

2. During medication administration observation, RN (registered nurse) #1 was observed inserting her fingers into the medication cups used to prepare and administer medications to Residents #7 and #8.

3. On 9/7/17 at 12:30 p.m. the lunch service was observed in the dining room. Multiple facility staff were observed serving or feeding residents without changing gloves or sanitizing their hands, after having touching residents, themselves or various items.

The findings include:

1. The facility staff failed to maintain infection control tracking, trending, and surveillance logs for 3 of the last 12 months (November 2016, December 2016, and May 2017.)

A review of the infection control tracking, trending, and surveillance logs was conducted. The months of November 2016, December 2016, and May 2017 were missing.

On 9/7/17 at approximately 3:00 p.m., in an interview with the Director of Nursing (ASM #2 -- Administrative Staff Member), she stated during those time periods, there were individuals assigned to maintain the logs that did not do it. ASM #2 stated neither individual was still employed at the facility. She was unable to

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provide any evidence the tracking, trending, and surveillance occurred during November 2016, December 2016, and May 2017.

A review of the facility policy, "Infection Control" documented, "2. The objectives of our infection control policies and procedures are to:
Identify, investigate, control, and prevent infections in the facility
Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public
Establish guidelines for the implementation of Isolation precautions
Maintain records of incidents and corrective actions related to infections
Establish guidelines to follow implementing Standard Precautions for the handling of blood, body fluids, secretions, excretions, mucous membranes and nonintact skin."

No further information was provided by the end of the survey.

2. The facility staff failed to follow infection control practices for 2 of 4 residents in the medication administration observation task; Residents #7 and #8.

Resident #7 was admitted to the facility on 6/1/16 with the diagnoses of but not limited to dementia, high blood pressure, hypothyroidism, chronic pain, macular degeneration, depression, and spinal disc disorder. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 6/8/17. The resident was coded as being cognitively intact in ability to make daily life

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decisions, scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Resident #8 was admitted to the facility on 4/26/17 with the diagnoses of but not limited to anxiety, heart failure, right hand fracture, chronic kidney disease, asthma, high blood pressure, hypothyroidism, and high cholesterol. The most recent MDS was a quarterly assessment with an ARD of 8/9/17. The resident was coded as being moderately impaired in ability to make daily life decisions.

On 9/7/17 at 8:36 a.m., RN #1 (Registered Nurse) was observed preparing and administering medications to Resident #7. She prepared the following medications for Resident #7:

Loratadine [1] 10 mg (milligrams)
Miralax [2] 17 gm (grams)
Aspirin [3] 81 mg
Norvasc [4] 2.5 mg
Senna [5] 8.6 mg

To prepare the medications, RN #1 obtained a 30 ml (milliliter) soufflé cup from the top of a stack of soufflé cups that were stored open-side up. While obtaining a cup from the top of the stack, RN #1's fingers were observed inserted down into the medication cup. RN #1 was then observed preparing each medication into the cup, and then she administered the medications to Resident #7 from this cup.

On 9/7/17 at 8:47 a.m., after administering medications to Resident #7, RN #1 was observed

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1. Residents #7 and #8 were not adversely affected. 9/7/17

2. Nurses immediately disposed of medication cups that were stacked improperly with open side up on each med cart. 9/7/17

3. Education conducted with all nursing staff reviewing proper storage of med cups with open side down on med carts. 9/25/17

   - Education conducted on policy and procedures for infection control and the importance of hand washing. 10/18/17

4. Unit Manager or designee will conduct audits of med carts 3x weekly for 4 weeks and then once weekly for 2 weeks. 10/20/17

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preparing medications for Resident #8. She prepared the following medications for Resident #8:

Xanax [6] 0.5 mg
Neurontin [7] 100 mg
Senna 8.6 mg
Bupropion [8] 150 mg
Norvasc 5 mg
Lasix [9] 20 mg

RN #1 obtained a 30 ml soufflé cup from the top of a stack of soufflé cups that were stored open-side up. When obtaining a cup from the top of the stack, RN #1's fingers were observed inserted down into the medication cup. RN #1 then prepared Resident #'s medications placing the medicines into this cup and was observed administering the medications to Resident #8 from this cup.

On 9/7/17 at approximately 2:00 p.m., in an interview with RN #1, she stated that she should not put her fingers into the cup, and she did not realize she had done that.

A review of the facility policy, "General Guidelines for Medication Administration" did not specifically document that staff should not touch or contaminate the inside of the medication cups. However, it did document, "6. c. Never touch any of the medication with fingers."

On 9/7/17 at approximately 5:30 p.m., the Administrator was made aware of the findings. No further information was provided by the end of the survey.

According to Potter and Perry's, Fundamentals of

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Nursing, 6th edition, page 847, "For safe administration, the nurse uses aseptic technique when handling and giving medications."

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 655. "The nurse follows certain principles and procedures, including standard precautions, to prevent and control infection and its spread. During daily routine care the nurse uses basic medical aseptic techniques to break the infection chain. A major component of client and worker protection is hand hygiene. Contaminated hands of health care workers are a primary source of infection transmission in health care settings."

References:

[1] Loratadine 10 mg (milligrams) is used to treat allergies. Information obtained from https://medlineplus.gov/druginfo/meds/a697038.html
[2] Miralax 17 gm (grams) is used to treat constipation. Information obtained from https://medlineplus.gov/druginfo/meds/a603032.html
[3] Aspirin 81 mg is used to treat pain, fever, and to help prevent clots in people at risk for strokes and heart attacks. Information obtained from https://medlineplus.gov/druginfo/meds/a682878.html
[4] Norvasc 2.5 mg is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a692044.html
[5] Senna 8.6 mg is used to treat constipation. Information obtained from https://medlineplus.gov/druginfo/meds/a601112.ht

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ml
[6] Xanax 0.5 mg is used to treat anxiety. Information obtained from https://medlineplus.gov/druginfo/meds/a684001.html
[7] Neurontin 100 mg is used to treat seizures, neuropathic pain, and restless leg syndrome. Information obtained from https://medlineplus.gov/druginfo/meds/a694007.html
[8] Bupropion 150 mg is used to treat depression, seasonal affective disorder, and to assist in smoking cessation. Information obtained from https://medlineplus.gov/druginfo/meds/a695033.html
[9] Lasix 20 mg is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a682858.html

3. On 9/7/17 at 12:30 p.m. the lunch service was observed in the dining room. Multiple facility staff were observed serving or feeding residents without changing gloves or sanitizing their hands, after having touching residents, themselves or various items.

CNA (certified nursing assistant) #3 obtained two clothing protectors from a cabinet at the back of the room. CNA #3 put one of the protectors on a resident and then moved to another table and put the clothing protector on another resident. CNA #3 then sat down and started feeding the resident. CNA #3 did not sanitize her hands between touching the first resident and the second resident.

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OSM #4, the dietary aide prepared a plate of food and took it to a resident. OSM #4 then went over to another resident, put her hand on the back of the resident's chair, placed the menu on the table and put her gloved hand on the menu and table top. OSM #4 took the resident's order, returned to the food steam table and picked up a soup bowl by putting her forefinger into the bowl and her thumb on the rim. She delivered the soup to the resident and was then told by OSM #7, the dining room manager to remove her gloves and wash her hands. OSM #4 did not change her gloves or wash her hands prior to returning to the food steam table; OSM #4 then picked up a soup bowl by putting her gloved fingers inside the bowl.

In the back of the dining room there was a square table. There were three residents seated at the table. CNA (certified nursing assistant) #2 was sitting at the left corner of the table between two residents. CNA #2 was sitting with his chin in his hand and his hand over his mouth. The resident to the right of CNA #2 had her food served and CNA #2 picked up the resident's knife and fork and cut up the food on the plate and began assisting the resident with eating. CNA #2 did not sanitize his hands prior to feeding the resident, after touching his face with his hands.

CNA #4 was sitting at the same table between two residents. CNA #4 picked up her chair and moved it to the other side of the resident sitting on the right side of the table. Prior to sitting down, CNA #4 pulled up her pants. CNA #4 then began feeding the resident to the right of her without sanitizing her hands. Another resident was placed at the table next to CNA #4. CNA #4 started feeding the resident and then turned and fed the

1. OSM #4 met with management to review policy and procedures regarding infection control. All nursing staff had handwashing procedures and infection control reviewed at change of shift. No residents were found to be adversely affected. — 9/7/17

2. In-services on infection control, concentrating on hand washing and proper glove use will be held for all dining and nursing staff. — 10/18/17

3. Additional dining staff will be provided during meal times for hot food service as well as cold food and beverages to eliminate need for nursing staff to go into the kitchen. — 9/11/17

   - Containers of alcohol based hand sanitizers were made available in the dining room for staff use. — 9/11/17
   - A second wall mount unit was installed as well. — 9/21/17
   - Better definitions of dining room staff duties were put in place. — 9/21/17

4. Unit Manager or designee will monitor dining room meal service for infection control issues 3x a week for 4 weeks and then once weekly for two weeks. — 10/20/17

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resident to her right. CNA #4 did not sanitize her hands after picking up her chair, pulling up her pants or prior to feeding one resident and then another.

An interview was conducted 9/7/17 at 1:12 p.m. with OSM #6, the dietary manager and OSM #7, the dining room manager. When asked when staff should change their gloves, OSM #7 stated, "They should change their gloves after they touch anything else then what they're serving. If they touch a resident or touch a table, they should wash their hands and put gloves back on."

An interview was conducted on 9/7/17 at 1:50 p.m. with OSM #4, the dietary aide. OSM #4 was asked the process staff followed when wearing gloves, OSM #4 stated, "Wash my hands before I put gloves on." When asked when she would remove her gloves and wash her hands, OSM #4 stated, "Whenever I touch anything but the food." OSM #4 was made aware of the above observation, OSM #4 stated, "I should have changed gloves and washed my hands."

An interview was conducted on 9/7/17 at 2:05 p.m. with CNA #2. When asked when staff wash their hands, CNA #2 stated, "Before and after care of course. Before and after bringing the meal into the room. Anytime you do any kind of care for anybody." When asked if staff sanitized their hands after touching their face and before feeding a resident, CNA #2 stated, yes. CNA #2 was made aware of the above observation. CNA #2 stated, "I should have washed my hands." When asked why staff wash their hands, "It's to stop the spreading of germs with the resident."

An interview was conducted on 9/7/17 at 2:10

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p.m. with CNA #4. When asked when staff wash their hands, CNA #4 stated, "Before you go into a room. Before you feed them. When you go into the dining room. The whole day is washing your hands." CNA #4 was made aware of the above observation. CNA #4 stated, "Yes. I should have washed my hands between the patients and after I picked up my chair."

An interview was conducted on 9/7/17 at 2:15 p.m. with CNA #3. When asked when staff wash their hands, CNA #3 stated, "When we get them up for the bathroom. Before we go in the room and after we work with the resident. Even if I put my hand on a door knob." CNA #3 was asked if she touched the resident when a clothing protector was put on, CNA #3 stated, "Yes." When made aware of the above observation, CNA #3 stated, "I should have washed my hands." When asked why, "Germs, to sanitize them (hands)."

An interview was conducted on 9/7/17 at 2:17 p.m. with RN (registered nurse) #3, the evening unit manager. When asked when staff should wash their hands, RN #3 stated, "Any patient care, before and after. Before serve food." When asked if staff were feeding one resident and then began feeding another resident should they sanitize their hands, RN #3 stated, "Yes, they should sanitize their hands."

On 9/7/17 at 5:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "HANDWASHING / HAND HYGIENE"

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F 441	Continued From page 32 documented, "Policy: (Name of facility) considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 1. Hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 5. Employees must wash hands for at least fifteen (15) seconds using antimicrobial or nonantimicrobial soap and water under the following conditions: c. Before and after direct resident contact; g. Before and after assisting a resident with meals." No further information was provided prior to exit.	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- (i) Sufficient information to identify the resident;	F 514		

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(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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 12 residents in the survey sample, Resident #6.

The facility staff failed to document Resident #6 requested pain medication be given instead of being offered non-pharmacological interventions for pain relief.

The findings include:

Resident #6 was admitted to the facility on 7/1/11 and readmitted on 8/31/17 with diagnoses that included but were not limited to: kidney stones, difficulty urinating, diverticulitis (1) and macular degeneration (2). The most recent MDS, a significant change assessment, with an ARD of 8/24/17 coded the resident as being understood and understanding others. The resident was coded as having an intact long-term and short-term memory. The resident was coded as

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requiring assistance from staff for all activities of daily living. In section J Health Conditions. Section JO300. Pain Assessment Interview. The resident was coded as having pain on a frequent basis. The resident was coded as having a ten out of ten on the pain rating scale, ten being the most severe pain.

Review of the care plan created on 5/23/17 documented "Pain Management. Resident has expressed/demonstration pain/discomfort related to: lt (left) shoulder pain, low back pain. APPROACH: Encourage resident to tell nurse when pain interventions are not being effective. Assist the resident as needed to position in a manner that is most comfortable; use pillows or other devises as needed."

Review of the physician's orders dated September 2017 documented, "Norco (3) 5 mg (milligrams) - 325 mg tablet...Give one tab (tablet) every 4hrs prn (as needed)."

Review of the medication administration record documented, "Norco 5 mg-325 mg tablet Give one tab every 4hrs prn." The medication was documented as being administered on 9/1/17, 9/2/17, 9/417 and 9/5/17.

Review of the nurse's notes dated 9/2/17 at 9:27 p.m. documented "prn lortab (another name for Norco) given for c/o pain left (no location) 5/10 with good results no pain at this time."

An interview was conducted on 9/7/17 at 3:22 p.m. with LPN (licensed practical nurse) #1, the day shift unit manager. When asked the process staff followed when a resident complained of pain, LPN #1 stated, "We do an assessment, find

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out where the pain is. We reposition first and then medicate if it doesn't work." When asked if this would be documented, LPN #1 stated, "Yes, in the nurse's notes." When asked to review the 9/2/17 nurse's notes, LPN #1 stated, "They should document what they did prior to giving the pain med (medication)."

An interview was conducted on 9/7/17 at 3:25 p.m. with LPN # 2, the nurse who administered the pain medication on 9/2/17 at 9:27 p.m. When asked what process staff followed when a resident complained of pain, LPN #2 stated, "We ask what the pain level is and document it." When asked if he had provided non-pharmacological interventions prior to medicating the resident, LPN #2 stated, "No. She asks for the pill and I gave it to her. I just didn't document it."

On 9/8/17 at 12:15 p.m. ASM (administrative staff member) #1 and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Pain Assessment and Management" documented, "Purpose. The purposes of this procedure are to help staff identify pain in the resident, and to develop interventions that address the underlying causes of pain. Defining Goals and Appropriate Interventions: 1. The pain management interventions shall be consistent with the resident's goals for treatment. Such goals will be specifically defined and documented."

No further information was provided prior to exit.

The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything

1. LPN #2 was counselled on the importance of non-pharmalogical interventions prior to administering PRN medication as well as the importance of documenting pain related information in file. Resident #6 was not found to be adversely affected. — 9/22/17

2. Pharmacy consultant will conduct an in-service pertaining to the importance of non-pharmalogical interventions before administering PRN medications. — 9/27/17

3. Nursing staff will review policy and procedures for pain management including non-pharmalogical interventions. — 9/27/17

4. Unit Manager or designee will perform random audits on all residents who receive PRN medication. — 9/27/17

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written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients." Potter and Perry (2005) also includes the following information: "As members of the health care team, nurses need to communicate information about clients accurately and in a timely, effective manner."

(1) Diverticulitis: Diverticular disease of the colon is among the most prevalent conditions in western society and is among the leading reasons for outpatient visits and causes of hospitalization. While previously considered to be a disease primarily affecting the elderly, there is increasing incidence among individuals younger than 40 years of age. Diverticular disease most frequently presents as uncomplicated diverticulitis, and the cornerstone of management is antibiotic therapy and bowel rest. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3174080/

(2) Macular Degeneration: Macular degeneration, or age-related macular degeneration (AMD), is a leading cause of vision loss in Americans 60 and older. It is a disease that destroys your sharp, central vision. You need central vision to see objects clearly and to do tasks such as reading and driving. This information was obtained from: https://medlineplus.gov/maculardegeneration.htm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	09/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(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 514	Continued From page 37	F 514		

(3) Norco: NORCO® is indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.