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

PRINTED: 08/15/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495389	A. BUILDING _____ B. WING _____	C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WINCHESTER, LLC	110 LAUCK DR WINCHESTER, VA 22603

(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 8/1/17 through 8/3/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 54 at the time of the survey. The survey sample consisted of 13 current resident reviews (Residents #1 through #12 and #17) and 4 closed record reviews (Residents #13 through #16).	F 000	**Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under State and Federal law.**	
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 164	**This Plan of Correction will serve as the Facility's allegation of substantial compliance** F Tag 164 1)Resident's No 12 MAR's was closed as soon as DCS was made aware of situation by the state surveyor. Education given to RN working on Policy and procedure for keeping MARS closed during medication pass. 2) Residents medication records will be kept closed during medication pass.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela Gee P. Duty RN, LNHA	Executive Director	9/6/2017

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

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F 164	Continued From page 1 records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to maintain privacy of the clinical record for one of 6 residents during medication administration; Resident #12. The facility staff left Resident #12's MAR (Medication Administration Record) open on top of the medication cart, while the cart was unsupervised, on 3 different occasions. Eight facility staff and 1 resident were observed passing by the cart during the 3 observations. The findings include: Resident #12 was admitted to the facility on 7/7/17 with the diagnoses of but not limited to:	F 164	3)Clinical staff will be educated On policy/procedure for privacy Of keeping Medical Records closed During medication pass on 08/30/2017. by the DCS. Education will be Given X 2 months(September /October) 4) A Medication Pass Observation will be complete on Clinical staff monthly x 2 months By the DCS/Unit manager to ensure Privacy of records is being maintained. (September/October) Results will be taken to QAPI for review and recommendations if needed. 5) Date of Compliance: 09/05/17 RECEIVED SEP 06 2017 VDH/OLC	

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tendonitis of the right shoulder, gait and mobility weaknesses, osteoporosis, high blood pressure, high cholesterol, low back pain, and Parkinson's Disease.

The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 7/14/17. Resident #12 was coded as being cognitively intact in ability to make daily life decisions, scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident required total care for bathing, hygiene, ambulation and transfers; supervision for eating; and was continent of bowel and bladder.

On 8/2/17 at 7:07 a.m., RN #1 (Registered Nurse) was observed preparing and administering medications to Resident #12. He prepared the following medications:

- Requip [1] 3 mg (milligrams), 1 tab (tablet)
- Synthroid [2] 88 mcg (micrograms), 1 tab
- Tylenol [3] 325 mg, 2 tabs

RN #1 then went into the resident's room, leaving the MAR open on top of the medication cart, with the front side of the cart facing the hallway. The cart was not in entire view of the nurse, as a majority of it was positioned to the side of the door, and not in front of the door. One staff member was observed passing by the medication cart.

During administration of the above medications, the resident requested some cough medicine.

On 8/2/17 at 7:14 a.m., RN #1 returned to the cart from the resident's room, reviewed the MAR for

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F 164	Continued From page 3	F 164		

an order for cough medicine and noted there wasn't any. He then went to the nurse's station to check the chart and obtain an order. RN #1 returned to the cart at 7:17 a.m., having left the MAR open and unsupervised for a second time. Four staff members passed by the cart.

On 8/2/17 at 7:19 a.m., RN #1 then went back into Resident #12's room to administer the tussin [4] cough medication he prepared. He left the MAR on top of the cart, open and unsupervised a 3rd time. One resident and 3 staff members were observed passing by the medication cart.

On 8/3/17 at approximately 9:30 a.m., an interview was conducted with LPN #2 (Licensed Practical Nurse). She stated that when a medication cart is left unsupervised, the drawers should be locked, the MAR should be closed, and medications, needles, etc., should not be left on top of the cart.

A review of the facility policy for Medication Administration did not document any criteria for ensuring the MAR was closed and the resident's medical information was kept private.

On 8/3/17 at approximately 2:00 p.m., the DON (Director of Nursing - Administrative Corporate Staff (ASM) #2) was made aware of the findings. No further information was provided by the end of the survey.

Basic Nursing, Essentials for Practice, 6th edition, Potter and Perry, pages 69-70 was used as a reference for confidentiality and read in part: "The concept of confidentiality in healthcare has widespread acceptance in the United States. Federal legislation known as HIPAA (Health

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Insurance Portability and Accountability Act of 1996) requires that those with access to personal health information not disclose the information to a third party without patient consent. HIPAA legislation defines the rights and privileges of patients for protection of privacy without diminishing access to quality care and sets fines for violations. You cannot copy or forward medical records without a patient's consent. Health care workers are not allowed to share health care information with others without specific patient consent. This includes laboratory results, diagnosis and prognosis. In addition, family members or friends of the patient are not permitted access to the patient's personal health information without the patient's consent."

References:

[1] Requip is used to treat the symptoms of Parkinson's Disease.
Information obtained from https://medlineplus.gov/druginfo/meds/a698013.html

[2] Synthroid is used to treat hypothyroidism.
Information obtained from https://medlineplus.gov/druginfo/meds/a682461.html

[3] Tylenol is used to treat mild to moderate pain.
Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html

[4] Tussin is used to relieve chest congestion by making it easier to cough up mucus and clear the airway.
Information obtained from

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F 164	Continued From page 5 https://medlineplus.gov/druginfo/meds/a682494.html	F 164		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced	F 226	F Tag 226 1)An FRI was submitted For Resident #7 allegation of abuse per regulation. 2 An investigation was conducted of staff on 08/3 and 08/4 and residents for any unreported abuse allegations FRI(s) submitted as indicated investigation conducted and staff suspended pending outcome of investigation as indicated. 3) Staff educated on 08/3 and 08/4/17 on policy/procedure of abuse reporting by the DCS/ED. Education of Abuse reporting is part of orientation and annual education calendar.	

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by:
Based on resident interview, staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to investigate an allegation of abuse for one of 17 residents, Resident #7.

On 7/11/17 Resident #7 communicated to the facility administrator, ASM (administrative staff member) #1, that a CNA (certified nursing assistant) #4, had "an attitude" with her. ASM #1 failed to follow the facility policies and procedures for investigating an allegation of verbal abuse.

The findings include:

Resident #7 was admitted to the facility on 1/3/16 with diagnoses that included, but were not limited to; anemia (a low red blood cell count), depression, acid reflux, low functioning thyroid and chronic kidney disease.

Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/10/17, coded Resident #7 as having a BIMS (brief interview of mental status) score of 15 out of a possible 15, indicating that Resident #7 is cognitively intact with daily decision making.

A review of the facility complaint/grievance reports revealed, in part, the following complaint; "Date Communicated. 7/11/17. Complaint/ Grievance: Communicated by: (a check mark by Resident and a check mark by Resident Council). Name: (name of Resident #7). Relationship; (self). Communicated to: (check mark beside Administrator). Name: (name of ASM #1).

4) Allegations of abuse will be investigated per policy and FRI sent, All sent will be taken to QAPI for review and recommendations if needed.

5) Date of Compliance: 09/05/17

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Communicated via; (check mark by Verbal). Concerned about: (check mark by other) CNA - Attitude. Describe concern in detail: Resident stated CNA (name of CNA #4) has an attitude with resident. Resident was afraid to report: Did tell (name of past ADON [assistant director of nursing]). Told (name of past ADON) she did not want it reported. Documentation of investigation; Assigned by: (name of ASM #1). Findings of investigation: spoke to (name of CNA #4) regarding concern, does not feel that she has attitude with resident, will be more friendly with resident when interacting with resident. Results of actions taken: resolved. Resolution; Complaint/ grievance resolved; (check mark by "yes") Complainant remarks: Resident states that CNA has been great to her and no more issues. Will let me know if any more problems."

A review of Resident #7's comprehensive care plan dated 11/22/16 did not reveal any documentation regarding abuse and psychosocial well-being.

An interview was conducted on 8/3/17 at 10:00 a.m. with ASM #2, the director of nursing. ASM #2 was asked to describe the process for an allegation of abuse. ASM #2 stated, "The staff member is suspended pending an investigation, the administrator is notified and a FRI (facility reported incident) is completed and sent to the state agency pending investigation." ASM #2 was asked if CNA #4 was still involved in caring for Resident #7, ASM #2 stated that she was. ASM #2 further stated that she was unaware of the grievance and she was not asked to investigate.

An interview was conducted by another surveyor on the survey team on 8/3/17 at 10:40 a.m. with

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ASM #3. the nurse practitioner. During the interview ASM #3 stated there was a CNA (CNA #4) who was rude to the residents. ASM #3 stated the staff was afraid to report this behavior to administration fearing their tires would be slashed.

An interview was conducted on 8/3/17 at 10:45 a.m. with ASM #3, the family nurse practitioner, in the presence of ASM #1, the administrator, and ASM #2 (the director of nursing). ASM #3 was asked if she was aware of any CNAs being verbally abusive to any of the residents in the facility. ASM #3 stated, "I have heard a CNA speak rudely to a resident, but I don't remember when." When asked which CNA, ASM #3 stated that it was CNA #4. When asked to describe the situation, ASM #3 stated, "She (CNA #4) was in one hallway and I heard her yelling at a resident in another hallway, I went to the nurse's station to see what the problem was." ASM #3 was asked if she intervened or if she reported the incident, ASM #3 stated, "The nurses were there, we discussed it, I am not sure if anyone intervened." When asked the name of the nurse present ASM #3 stated it was a nurse who was no longer employed with the facility. ASM #3 further stated that Resident #7 had confided that she was afraid of CNA #4, she was afraid of retaliation. ASM #3 was asked whether or not what she heard constituted abuse, ASM #3 stated it was verbal abuse. ASM #3 was asked if she was responsible for reporting allegations of abuse, ASM #3 stated that she was but did not do it.

On 8/3/17 at 10:50 a.m. ASM #1, the administrator, was asked specifically about the complaint/grievance report submitted to ASM #1 by Resident #7, and whether or not that was an

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allegation of abuse. ASM #1 stated, "I did not report this because I did not think it was abuse when I spoke to the resident and to (name of CNA #4)." ASM #1 was asked to describe her process when she was provided with an allegation of abuse. ASM #1 stated that she would conduct an investigation which involved obtaining a statement from person with the allegation, she would suspend the employee involved and would obtain witness statements from other staff members and other residents to determine whether or not there was abuse. When asked if she followed this process in this situation involving Resident #7, ASM #1 stated that she did not.

On 8/3/17 at approximately 12 noon an interview was conducted with Resident #7. Resident #7 was asked if she had a problem with CNA #4. Resident #7 stated that she (CNA #4) had an attitude problem with her and she had talked to the activities director who reported the situation to the administrator. Resident #7 further stated, "She (CNA #4) is better now, she is friendlier." Resident #7 was asked if she was fearful of retaliation, Resident #7 stated that she was not. Resident #7 was asked if CNA #4 was equally friendly to all residents, Resident #7 stated that the only thing that she could say was that (name of CNA #7) would slam things around and she (Resident #7) didn't like that. Resident #7 further stated that she didn't really want to talk about it.

On 8/3/17 at 12:30 p.m. ASM #1 was made aware of the conversation with Resident #7 and was asked when a FRI should be completed. ASM #1 stated anytime there was an allegation of abuse. ASM #1 further stated that (name of CNA #4) was alleged to "have an attitude" but was

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F 226	Continued From page 10 unable to state how that attitude was manifested. A review of the facility titled "Resident Abuse" revealed, in part, the following documentation: "Policy: It is inherent in the nature and dignity of each resident at The Company that he / she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, and / or misappropriation of property. Verbal Abuse: Statements made to a resident which result in ridicule or humiliation of the resident. Any use of oral, written or gestured language that includes cursing, disparaging and derogatory terms to other residents or visitors within hearing range, to describe residents, regardless of their age, ability to comprehend, or disability. Definition of Resident Abuse: An abusive act is any act or omission, which may cause or causes actual physical, psychological or emotional harm or injury to a resident or any act which willfully deprives resident of his rights by law or as stated herein. Investigation of Abuse: The abuse coordinator or his / her designee shall investigate all reports or allegations of abuse. Preliminary Investigation: Immediately upon an allegation of abuse or neglect, the suspect shall be segregated from the residents pending the investigation resident of the allegation (sic). Investigation: The abuse coordinator shall take statements from the victim, the suspect and all possible witnesses including all other employees in the vicinity of the alleged abuse." No further information was provided prior to the end of the survey process.	F 226		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272	F Tag 272 1)Resident #3 , #6, ~~#8~~ CAA summary worksheet of	

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F 272	Continued From page 11 (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members	F 272	Section V was updated To include the location and date of information For the trigger on 08/02/17 by the MDS RN. 2) Quality monitoring of CAA worksheet(s) of current residents reviewed by the IDT by 09/05/17 to ensure that the CAA has the location and date of the information for the trigger. Follow up based on findings of quality monitoring 3) Education will be given 08/28/17 to IDT by the ED on CAA worksheet on information requirement for location and date of the triggered area. 4) The DCS/designee to quality monitor 10% of CAA worksheets developed by the IDT monthly. Quality monitoring schedule modified based on findings Quality Monitoring results to be Reviewed by the QAPI committee For recommendations if needed. 5) Compliance Date: 09/05/2017	

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F 272	Continued From page 12 on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to document the location and date on the comprehensive MDS (minimum data set) for three of 17 residents in the survey sample, Resident #3, Resident #6 and Resident #8. 1. The facility staff failed to document the location and date of information for the triggered areas on the CAA Summary worksheet of Section V of Resident #3's five day admission MDS assessment with an ARD (assessment reference date) of 7/8/17. 2. The facility staff failed to document the location and date of information for the triggered areas on the CAA worksheet of Section V of Resident #6's five day admission MDS assessment with an ARD of 3/15/17. 3. The facility staff failed to document date and location information for the triggered areas on the CAA Summary worksheet of Section V of Resident #8's admission/5-day MDS assessment with an ARD (assessment reference date) of 4/21/17. The findings include:	F 272		

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1. The facility staff failed to document the location and date of information for the triggered areas on the CAA Summary worksheet of Section V of Resident #3's five day admission MDS assessment with an ARD (assessment reference date) of 7/8/17.

Resident #3 was admitted to the facility on 7/1/17 with diagnoses that included but were not limited to: falls, difficulty swallowing, irregular heartbeat, chronic kidney disease and dementia. The most recent MDS assessment was a 14 day assessment with an ARD (assessment reference date) of 7/15/17. The resident was coded as having a BIMS (brief interview for mental status) of 12 indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the CAA (care area assessment) worksheet on the five day admission MDS assessment with an assessment reference date of 7/8/17, revealed the following triggered areas did not evidence documentation as to the location and dates from where the information was obtained to complete the assessment: ADL (activities of daily living) functional/rehabilitation potential, urinary incontinence, psychosocial well-being, activities, falls, feeding tube, dehydration/fluid maintenance, pressure ulcer and psychotropic drug use.

An interview was conducted on 8/2/17 at 4:30 p.m. with RN (registered nurse) #5, the MDS coordinator. When asked why location and date was included on the CAA worksheet, RN #5 stated, "To make sure that anyone looking at the

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F 272	Continued From page 14 MDS knows where we got the information from." When asked where the location and date were documented, RN #5 stated, "The location and date is supposed to be on the CAA face sheet and on the CAA worksheet." RN #5 was asked to review Resident #3's CAA worksheet for the five day admission MDS assessment with an assessment reference date of 7/8/17. When asked if the location and dates of the information were documented, RN #5 stated, "No." When asked what reference the staff used to complete the MDS assessments, RN #5 stated, "The RAI (resident assessment instrument)." The staff member who completed the five day admission MDS assessment for Resident #3 no longer worked at the facility and could not be interviewed. On 8/2/17 at 6:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. According to the CMS's RAI Version 3.0 Manual: Section V of the MDS documents at the top of the page the following instructions: 1. Check column A if the Care Area is triggered. 2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Addressed in the Care Plan column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.	F 272		

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3. Indicate in the Location and Date of CAA information column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks and any referrals for this resident for this care area.

Review of CMS's (Center of Medicare/Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 User's Manual documented, "CHAPTER 4: CARE AREA ASSESSMENT (CAA) PROCESS AND CARE PLANNING. 4.5 Other Considerations Regarding Use of the CAAs. Use the "Location and Date of CAA Documentation" column on the CAA Summary (Section V of the MDS 3.0) to note where the CAA information and decision making documentation can be found in the resident's record. Also indicate in the column "Care Planning Decision" whether the triggered care area is addressed in the care plan."

No further information was provided prior to exit.

2. The facility staff failed to document the location and date of information for the triggered areas on the CAA worksheet of Section V of Resident #6's five day admission MDS assessment with an ARD of 3/15/17.

Resident #6 was admitted to the facility on 3/2/17 with diagnoses that included but were not limited to: stroke, diabetes and difficulty speaking. Review of the most recent MDS assessment, a quarterly assessment, with an ARD of 6/15/17 coded the resident as being moderately impaired to make daily decisions. The resident was coded

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as being independent in activities of daily living.

Review of the CAA (care area assessment) worksheet on Resident #6's admission MDS assessment with an ARD of 3/15/17 revealed the following triggered areas did not evidence documentation as to the location and dates from where the information was obtained to complete the assessment: cognitive loss, communication, behavioral symptoms, falls, pressure ulcer and psychotropic drug.

An interview was conducted on 8/2/17 at 4:30 p.m. with RN (registered nurse) #5, the MDS coordinator. When asked why location and date was included on the CAA worksheet, RN #5 stated, "To make sure that anyone looking at the MDS knows where we got the information from." When asked where the location and date were documented, RN #5 stated, "The location and date is supposed to be on the CAA face sheet and on the CAA worksheet." RN #5 was asked to review Resident #3's CAA worksheet from the admission MDS assessment with an ARD of 3/15/17. When asked if the location and dates of the information were documented, RN #5 stated, "No."

The staff member who completed the five day admission MDS for Resident #3 no longer worked at the facility and could not be interviewed.

On 8/2/17 at 6:00 p.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 obtained prior to exit.

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3. The facility staff failed to document date and location information for the triggered areas on the CAA Summary of Section V of Resident #8's admission/5-day MDS assessment with an ARD (assessment reference date) of 4/21/17.

Resident #8 was admitted to the facility on 9/13/16 and most recently readmitted on 4/14/17 with the diagnoses of but not limited to dementia, respiratory failure, high blood pressure, diabetes, asthma, low back pain, hypothyroidism, high cholesterol, depression, anxiety, Parkinson's Disease, Pick's Disease, epilepsy, migraines, apnea, chronic obstructive pulmonary disease, osteoarthritis, kidney disease and cancer of the renal pelvis.

The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/22/17. The resident was coded as being cognitively intact in ability to make daily life decisions, scoring a 14 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing; supervision for transfers, dressing, and hygiene; as independent for eating; and as continent of bowel and bladder.

A review of the admission/5-day MDS assessment with an ARD of 4/21/17, documented in Section V - Care Area Assessment (CAA) Summary" that the resident triggered for the following areas:

02. Cognitive Loss/Dementia
05. ADL Functional/Rehabilitation Potential
06. Urinary Incontinence and Indwelling Catheter
09. Behavioral Symptoms
11. Falls

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F 272	Continued From page 18 12. Nutritional Status 14. Dehydration/Fluid Maintenance 16. Pressure Ulcer 17. Psychotropic Drug Use 19. Pain Next to each of the above listed areas, in the column titled "Location and Date of CAA documentation" was documented, "CAA WS (worksheet) dated 4/27/17" except for 09. Behavioral Symptoms which was dated 5/1/17 and 19. Pain which was dated 4/28/17. A review of the CAA worksheets revealed that only section 12. Nutritional Status, contained any clinical record date and location documentation. The areas of 02. Cognitive Loss/Dementia, 05. ADL Functional/Rehabilitation Potential, 06. Urinary Incontinence and Indwelling Catheter, 09. Behavioral Symptoms, 11. Falls, 14. Dehydration/Fluid Maintenance, 16. Pressure Ulcer, 17. Psychotropic Drug Use, and 19. Pain did not contain any date and location information. On 8/3/17 at approximately 10:00 a.m., an interview was conducted with RN #5 (Registered Nurse - the MDS nurse). She stated that location and date information should be on the CAA worksheet or documented in Section V of the MDS. RN #5 reviewed the above MDS and stated that the date and location information was not documented, and therefore, the information used to complete the MDS could not be tracked. She stated the person that completed this MDS was no longer at the facility. When asked what policy the facility uses to complete the MDS, RN #5 stated the RAI manual (Resident Assessment Instrument).	F 272		

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F 272	Continued From page 19 On 8/3/17 at approximately 2:00 p.m., the DON (Director of Nursing - Administrative Corporate Staff (ASM) #2) was made aware of the findings. No further information was provided by the end of the survey.	F 272		
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 - (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	F 279	F Tag 279 1)Resident #3 care plan for Psychosocial well–being was updated and Resident #6 care plan for behavior was updated on 08/02/17. by the MDS RN. 2) Care plans of current residents reviewed by the IDT 09/05/17 to ensure that care plans are current and complete according to the triggered CAA .Follow up based on findings 3) Education given 08/28/17 to IDT by the ED on developing a care plan that Is complete according to the CAA that is triggered, to include psychosocial well-being and behavior care plan from information gathered.	

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F 279	Continued From page 20 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 staff interview, facility document review and clinical record review, it was determined that facility staff failed to develop a comprehensive care plan for two of 17 residents in the survey sample, Resident #3 and Resident #6. 1. The facility staff failed to develop a comprehensive care plan for psychosocial well-being for Resident #3 as identified on the CAA (care area assessment) of the five day	F 279	4) The DCS to quality monitor 10% of care plans developed by the IDT monthly to ensure triggered CAA is care planned. Monitoring results to be reviewed by the QAPI committee for recommendations if needed. Quality monitoring schedule modified based on findings. 5) Compliance Date: 09/05/2017	

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admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 7/8/17.

2. The facility staff failed to develop a comprehensive care plan for behavior for Resident #6 as identified on the CAA of the admission MDS assessment with an ARD of 3/15/17.

The findings include:

1. The facility staff failed to develop a comprehensive care plan for psychosocial well-being for Resident #3 as identified on the CAA (care area assessment) of the five day admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 7/8/17.

Resident #3 was admitted to the facility on 7/1/17 with diagnoses that included but were not limited to: falls, difficulty swallowing, irregular heartbeat, chronic kidney disease and dementia.

The most recent MDS assessment was a 14 day assessment, with an assessment reference date of 7/15/17. The resident was coded as having a BIMS (brief interview for mental status) of 12 indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the CAA (care area assessment) summary on the five day admission MDS with an assessment reference date of 7/8/17 documented in section V. Care Area, 07. Psychosocial Well-Being; A. Care Area Triggered,

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an X was documented (indicating the area was triggered); B. Care Planning Decision, an X was documented (indicating a care plan would be developed for psychosocial well-being).

Review of Resident #3's comprehensive care plan initiated on 7/12/17 did not evidence documentation for a psychosocial well-being plan of care.

An interview was conducted on 8/2/17 at 2:00 p.m. with LPN (licensed practical nurse) #4, unit manager. When asked which staff used the comprehensive care plan, LPN #4 stated, "All the nurses look at the care plan. Social services can utilize the care plan." When asked why residents had comprehensive care plans, LPN #4 stated, "That is the plan of care for the patient."

An interview was conducted on 8/2/17 at 4:30 p.m. with RN (registered nurse) #5, the MDS coordinator. When asked who would develop a care plan for psychosocial well-being, RN #5 stated, "The social worker."

An interview was conducted on 8/2/17 at 4:45 p.m. with OSM (other staff member) #7, the social worker. OSM #7 was asked about the process followed when a CAA triggered an area for a care plan to be developed. OSM #7 stated, "I go into the CAA worksheet and develop a care plan from that." When asked why a care plan was developed, OSM #7 stated, "Because it's important to know if they (the residents) have issues we need to develop a plan so everyone knows about it and to see they get the care they deserve." OSM #7 was asked to review Resident #3's CAA worksheet from the five day admission MDS assessment with an assessment reference

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date of 7/8/17. OSM #7 stated that a care plan should be developed for psychosocial well-being. OSM #7 was asked to review Resident #3's comprehensive care plan for psychosocial well-being. OSM #7 stated, "It's not there."

On 8/2/17 at 6:00 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, "Plans of Care" documented in part, "Policy: An interdisciplinary plan of care will be established for each resident and updated in accordance with state and federal regulatory requirements and on an ongoing basis. Procedure: The facility will develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Direct care staff should be aware, understand and follow their Resident's Plan of Care."

No further information was provided prior to exit.

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another.

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F 279	Continued From page 24 If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care." 2. The facility staff failed to develop a comprehensive care plan for behavior for Resident #6 as identified on the CAA of the admission MDS assessment with an ARD of 3/15/17. Resident #6 was admitted to the facility on 3/2/17 with diagnoses that included but were not limited to: stroke, diabetes and difficulty speaking. Review of the most recent MDS, a quarterly assessment, with an ARD of 6/15/17 coded Resident #6 as being moderately impaired to make daily decisions. The resident was coded as being independent in activities of daily living. Review of the CAA summary from Resident #6's admission MDS with an ARD of 3/15/17 in section V documented, Care Area 09. Behavioral Symptoms. A. Care Area Triggered, an X was documented (indicating the care area was triggered); B. Care Planning Decision an X was documented (indicating a care plan would be developed). Review of Resident #6's comprehensive care plan initiated on 3/16/17 did not evidence documentation of a behavior care plan. An interview was conducted on 8/2/17 at 2:00 p.m. with LPN (licensed practical nurse) #4, unit manager. When asked which staff used the care	F 279		

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plan, LPN #4 stated, "All the nurses look at the care plan. Social services can utilize the care plan." When asked why residents had care plans, LPN #4 stated, "That is the plan of care for the patient."

An interview was conducted on 8/2/17 at 4:30 p.m. with RN (registered nurse) #5, the MDS coordinator. When asked who would develop a care plan for behavioral symptoms, RN #5 stated, "The social worker."

An interview was conducted on 8/2/17 at 4:45 p.m. with OSM (other staff member) #7, the social worker. OSM #7 was asked about the process staff followed when a CAA triggered for a care plan to be developed. OSM #7 stated, "I go into the CAA worksheet and develop a care plan from that." When asked why a care plan was developed, OSM #7 stated, "Because it's important to know if they (the residents) have issues we need to develop a plan so everyone knows about it and to see they get the care they deserve." OSM #7 was asked to review Resident #6's CAA worksheet from the admission MDS assessment with an ARD of 3/15/17. OSM #7 stated that a care plan should be developed for behavioral symptoms. OSM #7 was asked to review Resident #6's comprehensive care plan for behavioral symptoms. OSM #7 stated, "It's not there."

On 8/2/17 at 6:00 p.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.

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F 281 SS=D	Continued From page 26 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to follow professional standards of practice for one of 17 residents in the survey sample, Resident #3; and for two of six residents in the medication pass observation, Resident #5 and Resident #17. 1. The facility staff failed to clarify Resident #3's weight change from 206 pounds on 7/1/17 to 169 pounds on 7/17/17. 2. The facility staff prepared medications for both Resident #5 and Resident #17 at the same time, before entering the room to administer the medications to both residents. The findings include: 1. Facility staff failed to clarify Resident #3's weight change from 206 pounds on 7/1/17 to 169 pounds on 7/17/17. Resident #3 was admitted to the facility on 7/1/17 with diagnoses that included but were not limited to: falls, difficulty swallowing, irregular heartbeat, chronic kidney disease and dementia.	F 281 F 281	F Tag 281 1)Resident # 3 Clinical record Was updated on 08/02/27 to clarify the correct weight by the MDS RN. Medication nurse was Educated by the DCS on proper Medication administration when The state surveyor made her aware Of Resident #5 and #17 medications Being given at the same time On 08/2/17. 2) A review of current residents Weights conducted on 08/29/17 to ensure that weights are correct and documented accordingly. Licensed nurses observed during medication pass to ensure only one resident's medications being given at a time by the DCS/Unit manager 5 x week x 2 weeks starting 08/28/2017 then weekly times 4 weeks then monthly. Quality monitoring schedule modified based on findings.. 3) Education provided on 08/30/17 To weight committee by the DCS on the Policy/Procedure of obtaining and	

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The most recent MDS (minimum data set), was a 14 day assessment, with an assessment reference date (ARD) of 7/15/17. The resident was coded as having a BIMS (brief interview for mental status) of 12 indicating the resident was cognitively intact to make daily decisions. Resident #3 was coded as requiring assistance from staff for all activities of daily living. The resident was coded as receiving tube feedings. In Section K of the MDS the resident's weight was documented as being 169 pounds.

Review of Resident #3's admission MDS assessment with an ARD of 7/8/17 in section K revealed the resident's weight was documented as being 206 pounds.

Review of the nursing admission assessment dated 7/1/17 at 4:50 p.m. documented the resident's weight as being 206.4 pounds.

Review of the nurse's notes did not evidence documentation regarding the weight change of 37 pounds in 14 days.

Review of Resident #3's vital signs and weight record documented, "7/1/17 -- 206.4. 7/15/17 -- 169.8." There was no documentation regarding the weight change on the form. The nurse who entered in the weight on 7/15/17 was not available to be interviewed.

An interview was conducted on 8/2/17 at 4:30 p.m. with RN (registered nurse) #5, the MDS coordinator. When asked who entered the weights into the MDS assessments, RN #5 stated, "Dietary puts in the heights and weights." When asked who reviews the information in the

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Documenting correct weights. Education given by the DCS to licensed nurses on 08/30/17 on correct policy/procedure for medication pass.

4) Quality monitoring conducted weekly times 4 weeks then monthly
On 15% of current residents weights by the
DCS/Designee to ensure compliance.
Monthly observations completed on Licensed nurses on Medication pass to Ensure compliance. Results of quality monitoring taken to monthly QAPI meeting for review
and recommendations if needed.

5) Compliance Date: 09/05/17

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MDS assessments, RN #5 stated she did. RN #5 stated, "When the MDS is locked there would have been a warning that there was a significant change. Someone had to override the warning."

An interview was conducted on 8/3/17 at 8:45 a.m. with CNA (certified nursing assistant) #2. When asked about the process the staff follows for a significant change in a resident's weight, CNA #2 stated, "If there is a discrepancy the nurse comes to us to have them (residents') weighed again."

An interview was conducted on 8/3/17 with LPN (licensed practical nurse) #4, the unit manager. When asked about the process staff follows if a resident has a significant change in weight, LPN #4 stated, "That would trigger something was wrong. It's clear the admission weight was wrong." When asked what staff did when they discovered an error, LPN #4 stated, "We alert the physician and make a clarification note." When asked why an accurate weight was important, LPN #4 stated, "It's important to know if there's a loss or a gain. If they (residents') are losing weight, maybe the tube feeding she's getting isn't the precise amount.

An interview was conducted on 8/3/17 at 12:10 p.m. with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked to review Resident #3's nursing admission and vital signs and weight records. When asked about the process staff follows when there was a significant change in a resident's weight, ASM #2 stated, "I would have thought she would have looked at the weight sheet and crossed off the 206.4 weight." When asked why staff did weights, ASM #2 stated, "To see if they are losing weight or have a

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nutrition problem. We give it to the dietitian." ASM #2 was asked what professional standard the facility used. ASM #2 stated, "We use our policies." A request for a policy on clarification and documentation of a discrepancy in a resident's condition was requested; ASM #2 stated they did not have a policy.

The RN who completed the MDS no longer worked at the facility and was unable to be interviewed.

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 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."

2. The facility staff prepared medications for both Resident #5 and Resident #17 at the same time, before entering the room to administer the medications to both residents.

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Resident #5 was admitted to the facility on 1/26/16 and readmitted on 7/28/17 with the diagnoses of but not limited to: sepsis, acute kidney failure, sleep apnea, large intestine cancer, morbid obesity, high cholesterol, depression with psychotic features, chronic pain syndrome, high blood pressure, overactive bladder, a colostomy, an artificial eye, and diabetes. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/13/17. The resident was coded as being cognitively intact in ability to make daily life decisions, scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Resident #17 was admitted on 7/18/17 with the diagnoses of but not limited to: cancer of the breast, ovary, kidney, and lung; depression, restless leg syndrome, cataracts, heart disease, spinal stenosis, high cholesterol, anxiety, and chronic obstructive pulmonary disease. Due to the recent admission, the MDS was not yet completed. The admission nursing assessment documented that the resident was oriented to person, place and time; short and long term memory were intact; and the resident was independent for decision making.

On 8/2/17 at 8:15 a.m., LPN #2 (Licensed Practical Nurse) was observed preparing and administering medications for Resident #5. She prepared the following medications:

- Vitamin D [1] 1000 units, 1 tab (tablet)
- Aspirin [2] 81 mg (milligrams), 1 tab
- Ferrous sulfate [3] 325 mg, 1 tab
- Lanuts [4] 37 units (injection)

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" Metformin [5] 1000 mg, 1 tab
" Diflucan [6] 100 mg, 2 tabs
" Loratadine [7] 10 mg, 1 tab
" Oxybutynin [8] 10 mg, 1 tab
" Multivitamin [9], 1 tab
" Novolog [10] 10 units (injection)

LPN #2 was then observed preparing medications for Resident #17. LPN #2 prepared the following medications for Resident #17:

" Lovenox [11] 40 mg (injection)
" Folic Acid [12] 1 mg, 1 tab
" Spiriva [13] 18 mcg (micrograms) (inhaler)
" Aspirin 81 mg, 1 tab
" Zyrtec [14] 10 mg, 1 tab
" Zoloft [15] 100 mg, 1 tab
" Depakote [16] 250 mg, 1 tab
" Neurontin [17] 300 mg, 1 tab
" Symbicort [18] 160-4.5 mcg (inhaler)
" Sucralfate [19] 100 mg, 1 tab
" Vitamin D 1000 units, 1 tab
" Bactrim DS [20], 1 tab
" Percocet [21] 5/325 mg, 2 tabs

LPN #2 then put on PPE (personal protective equipment, i.e., gown, gloves) and went into the room to administer medications to both of the residents.

On 8/3/17 at approximately 9:30 a.m., an interview was conducted with LPN #2 (Licensed Practical Nurse). When asked about preparing medications for more than one resident at a time, she stated that she did not know that she couldn't do that. LPN #2 stated that since one resident in the room was being treated for an infection, she thought it was ok to prepare the medications for both residents in the room at the same time.

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A review of the facility policy for Medication Administration documented, in all capital letters, "PREPARE MEDICATION FOR ONLY ONE RESIDENT AT A TIME."

On 8/3/17 at approximately 2:00 p.m., the DON (Director of Nursing - Administrative Corporate Staff (ASM) #2) was made aware of the findings. No further information was provided by the end of the survey.

References:

[1] Vitamin D helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and immune systems.
Information obtained from https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=vitamin+d&_ga=2.192500842.1377447934.1502114951-734861906.1502114951

[2] Aspirin is used to prevent heart attacks in people who have had a heart attack in the past or who have angina (chest pain that occurs when the heart does not get enough oxygen); to reduce the risk of death in people who are experiencing or who have recently experienced a heart attack; to prevent ischemic strokes (strokes that occur when a blood clot blocks the flow of blood to the brain) or mini-strokes (strokes that occur when the flow of blood to the brain is blocked for a short time) in people who have had this type of stroke

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or mini-stroke in the past. Aspirin will not prevent hemorrhagic strokes (strokes caused by bleeding in the brain). Aspirin is in a group of medications called salicylates. It works by stopping the production of certain natural substances that cause fever, pain, swelling, and blood clots. Information obtained from https://medlineplus.gov/druginfo/meds/a682878.html

[3] Ferrous sulfate provides the iron needed by the body to produce red blood cells. It is used to treat or prevent iron-deficiency anemia, a condition that occurs when the body has too few red blood cells because of pregnancy, poor diet, excess bleeding, or other medical problems. Information obtained from https://medlineplus.gov/druginfo/meds/a682778.html

[4] Lanuts is a long-acting, man-made version of human insulin. Insulin glargine works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar. Information obtained from https://medlineplus.gov/druginfo/meds/a600027.html

[5] Metformin is used alone or with other medications, including insulin, to treat type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood). Information obtained from https://medlineplus.gov/druginfo/meds/a696005.html

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[6] Diflucan is used to treat fungal infections, including yeast infections of the vagina, mouth, throat, esophagus (tube leading from the mouth to the stomach), abdomen (area between the chest and waist), lungs, blood, and other organs. Information obtained from https://medlineplus.gov/druginfo/meds/a690002.html

[7] Loratadine is used to temporarily relieve the symptoms of hay fever (allergy to pollen, dust, or other substances in the air) and other allergies. Information obtained from https://medlineplus.gov/druginfo/meds/a697038.html

[8] Oxybutynin is used to treat overactive bladder (a condition in which the bladder muscles contract uncontrollably and cause frequent urination, urgent need to urinate, and inability to control urination) control urgent, frequent, or uncontrolled urination in people who have overactive bladder (a condition in which the bladder muscles have uncontrollable spasms). Information obtained from https://medlineplus.gov/druginfo/meds/a682141.html

[9] Multivitamin/mineral supplements contain a combination of vitamins and minerals. They sometimes have other ingredients, such as herbs. They are also called multis, multiples, or simply vitamins. Multis help people get the recommended amounts of vitamins and minerals when they cannot or do not get enough of these nutrients from food. Information obtained from https://medlineplus.gov/definitions/vitaminsdefinitions.html

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[10] Novolog is a short-acting, manmade version of human insulin. Insulin aspart works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar.
Information obtained from https://medlineplus.gov/druginfo/meds/a605013.html

[11] Lovenox is used to prevent blood clots in the leg in patients who are on bedrest or who are having hip replacement, knee replacement, or stomach surgery. It is used in combination with aspirin to prevent complications from angina (chest pain) and heart attacks. It is also used in combination with warfarin to treat blood clots in the leg.
Information obtained from https://medlineplus.gov/druginfo/meds/a601210.html

[12] Folic acid is a B vitamin. It helps the body make healthy new cells.
Information obtained from https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=folic+acid&_ga=2.268000206.1377447934.1502114951-734861906.1502114951

[13] Spiriva is used to prevent wheezing, shortness of breath, coughing, and chest tightness in patients with chronic obstructive pulmonary disease (COPD, a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead

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to the lungs) and emphysema (damage to air sacs in the lungs).
Information obtained from https://medlineplus.gov/druginfo/meds/a604018.html

[14] Zyrtec is used to temporarily relieve the symptoms of hay fever (allergy to pollen, dust, or other substances in the air) and allergy to other substances (such as dust mites, animal dander, cockroaches, and molds).
Information obtained from https://medlineplus.gov/druginfo/meds/a698026.html

[15] Zoloft is used to treat depression, obsessive-compulsive disorder (bothersome thoughts that won't go away and the need to perform certain actions over and over), panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks), posttraumatic stress disorder (disturbing psychological symptoms that develop after a frightening experience), and social anxiety disorder (extreme fear of interacting with others or performing in front of others that interferes with normal life). It is also used to relieve the symptoms of premenstrual dysphoric disorder, including mood swings, irritability, bloating, and breast tenderness.
Information obtained from https://medlineplus.gov/druginfo/meds/a697048.html

[16] Depakote is used alone or with other medications to treat certain types of seizures; to treat mania (episodes of frenzied, abnormally excited mood) in people with bipolar disorder (manic-depressive disorder; a disease that

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causes episodes of depression, episodes of mania, and other abnormal moods); to prevent migraine headaches, but not to relieve headaches that have already begun. Information obtained from https://medlineplus.gov/druginfo/meds/a682412.html

[17] Neurontin is used to help control certain types of seizures in people who have epilepsy; to relieve the pain of postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles); to treat restless legs syndrome (RLS; a condition that causes discomfort in the legs and a strong urge to move the legs, especially at night and when sitting or lying down). Information obtained from https://medlineplus.gov/druginfo/meds/a694007.html

[18] Symbicort is used to treat wheezing, shortness of breath, and breathing difficulties caused by chronic obstructive pulmonary disease (COPD; a group of lung diseases that includes chronic bronchitis and emphysema). Information obtained from https://medlineplus.gov/druginfo/meds/a602023.html

[19] Sucralfate is used to treat and prevent the return of duodenal ulcers (ulcers located in first part of the small intestine). Treatment with other medications, such as antibiotics, may also be necessary to treat and prevent the return of ulcers caused by a certain type of bacteria (H. pylori). Information obtained from https://medlineplus.gov/druginfo/meds/a681049.h

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F 281	Continued From page 38 tml [20] Bactrim DS is used to treat certain bacterial infections, such as pneumonia (a lung infection), bronchitis (infection of the tubes leading to the lungs), and infections of the urinary tract, ears, and intestines. It also is used to treat 'travelers' diarrhea. Information obtained from https://medlineplus.gov/druginfo/meds/a684026.html [21] Percocet is used to relieve moderate to severe pain. Information obtained from https://medlineplus.gov/druginfo/meds/a682132.html	F 281		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, and in the course of a complaint investigation it was determined that the facility staff failed to administer medications in a manner to prevent a significant medication error for one of 17 residents in the survey sample, Resident # 15. The facility staff administered 2025 milligrams of Lyrica [used to relieve pain (1)] to Resident # 15	F 333	F Tag 333 1)Resident#15 as he no longer resides in the facility. MD was made aware and measures put into place to ensure resident #15 condition was monitored for any adverse reactions, none noted.	

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on 1/11/17, exceeding the dosage ordered by the physician.

The findings include:

Resident # 15 was admitted to the facility on 1/7/17 with diagnoses including but not limited to: anemia, atrial fibrillation (2), coronary artery disease (3), diabetes, and hyperlipidemia. Resident # 15's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/14/17, coded the resident as cognitively intact to make daily decisions, scoring 15 out of 15 on the BIMS (brief interview for mental status). Resident # 15 was discharged from the facility on 1/17/17.

A review of the physician's orders for Resident # 15 revealed, in part, the following: "Lyrica 225 mg (milligram) po (by mouth) BID (two times a day)". This order was signed by the physician on 1/9/17.

Review of the "CONTROLLED MEDICATION UTILIZATION RECORD" (a record used to document and keep track of controlled medications) for Resident # 15's documented: "LYRICA 225 MG CAPSULE ...1/11/17 at 9:00 p.m., DOSE GIVEN -- 9." This line of the document contained the initials of RN (registered nurse) # 3.

A review of the facility investigation of this incident revealed a description of this incident signed by RN # 3 dated 1/27/17. Review of this description revealed, in part, the following: "On evening of 1-11-17 @ 9 pm while administering medication (name of RN # 3) gave 9 lyrica tabs (symbol for with) dosage of 225 mg each for a total of 2,025 mg which is 8 (sic) times the dosage prescribed.

2)Quality Review completed by DCS/designee of Medical Records of current residents for any medication discrepancies by 08/30/2017 to ensure no medication errors.

3)Education provided to Licensed nurses on 08/30/17 By the DCS on correct medication Administration and the 6 rights when administrating medications.

4)DCS/and or pharmacy consultant to observe medication observations on licensed nurses for safe and accurate medication administration monthly. The results will be taken to QAPI Committee for recommendations if needed.

5)Date of Compliance: 09/05/2017

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(Name of RN # 3) did not follow the 6 rights of medication administration. 1. Right drug; 2. Right dose; 3. Right time; 4. Right resident; 5. Right route; 6. Right documentation."

When the overdose was discovered on the morning of 1/12/17 the physician was notified and initially ordered IV (intravenous fluids). When the physician arrived at the facility and assessed the Resident he then discontinued the order for IV fluids.

The Physician Progress Note of 1/12/17 at 10:30 a.m. documented the following:
Subjective: 80 year old male...was given about 2000 mg (milligrams) of Lyrica last night - prescribed dose was 225 mg. Patient denies ill feeling, dizziness, confusion, nausea or abdominal cramping. Vital Signs: T (temperature) 98.9 P (pulse) 71, R (respirations) 18, BP (blood pressure) 100/49. EXAM: Alert and oriented X 3, Lungs clear, cardio vascular system - regular rate and rhythm, no edema, no swelling, no tremor...Assessment & Plan: A. Medication Error, Lyrica overdosing without any obvious consequences...B. Monitor Vital signs every two hours for remainder of shift; hold Lasix and KCL today and resume tomorrow, continue other meds (medications). Restart Lyrica tomorrow.

The physician wrote the following order dated 1/12/17: "1. Monitor V/S (vital signs) Q (every) 2 hrs. & Neuro Checks Q 2 hrs X 24 hrs. 2. Hold Lyrica, Lasix & KCL today 1/12/17. 3. May resume all tomorrow."

Review of the Neurological Assessment Flow Sheet revealed documentation that the order for

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the Vital Signs and Neuro Checks was carried out. Review of the MAR (medication administration record) revealed documentation that the medications were held as ordered.

Other than the drop in blood pressure that was addressed on 1/12/17 at 1705 (noted in the Physician Progress Note below) the vital signs and Neuro Checks were within normal limits.

Physician Progress Note on 1/12/17 at 1705 (5:05 p.m.) documented the following: Subjective: Re-evaluated in room due to hypotension status post Lyrica overdose. Spouse present. Denies dizziness, dyspnea (shortness of breath) or chest pain. States, "I just don't feel good." Vital Signs: BP (blood pressure) 80/44, 98/62. Exam: Sitting up on side of bed. Awake, alert, NAD (no acute distress)), respirations non-labored. Lungs clear and diminished. Apical pulse regular. Assessment and Plan: 1. Overdose - approximately 2000 mg Lyrica given last hours of sleep. Hypotensive at times. Begin Intravenous fluids...continue to monitor.

Physician Progress Note of 1/13/17 at 1700 (5:00 p.m.) documented the following: Subjective: 80 year old male re-evaluated today after medication error involving Lyrica. Reports "feels better" today. Denies headache, dizziness, dyspnea, chest pain, palpations, no abdominal pain or bowel/bladder concerns...Vital signs: T (temperature) 97.9, P (pulse) 63, R (respirations) 16, and BP (blood pressure) 102/49. Exam: up in wheelchair. Awake, Alert, NAD (no acute distress), respirations non-labored. Lungs diminished...Apical regular. Surgical wounds to chest healing no S/S (signs /symptoms) of infection...Assessment and Plan: Medication error

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- no apparent adverse reaction, generalized weakness. Consider changing Lasix to every other day. Labs (laboratory tests) on 1/16/17 and Fax labs to cardio-thoracic.

RN # 3 was unable to be interviewed as she was no longer employed at the facility.

During an interview on 8/2/17 at 4:40 p.m. with LPN (licensed practical nurse) # 2, LPN # 2 was asked what she would do if while passing medications she had an unusual medication order or a medication with which she was not familiar. LPN # 2 stated that she would clarify the order by checking the medication card against the MAR (medication administration record) and also against the physician order. LPN # 2 further stated that if she still had a question she would call the physician and possibly the pharmacy. LPN # 2 stated she has to follow the six rights of medication administration and then named the rights.

During an the end of day interview on 8/2/17 at approximately 6:00 p.m. with ASM (Administrative staff member) # 1, the administrator, and ASM # 2, the Director of Nurses, this concern of the medication error was reviewed and the medication administration policy was requested.

Review of the facility policy "Medications - Oral Administration Of N-853" documented the following under "Policy: It is the policy that the resident can expect safe and accurate administration of oral medication. Procedure: Obtain and verify physician order. Take MAR and Medication Cart to hallway outside resident's room. Verify Physician's Order Sheet with MAR if any uncertainties exist. Check PDR (Physician's

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Desk Reference) or Nursing Drug Handbook for any unfamiliar medications. PREPARE MEDICATION FOR ONLY ONE RESIDENT AT A TIME. Locate prescribed medication in Medication Chart ...Compare unit/dose medication on MAR. Read label on the container THREE (3) TIMES: BEFORE REMOVING the drug from the drawer; BEFORE HANDING the drug to the resident; and BEFORE DISCARDING package ...Chart on MAR according to policy ..."

During an interview on 8/3/17 at approximately 9:00 a.m. with ASM # 1, ASM # 2, and ASM # 4, the Regional Director of Clinical Services, this concern was reviewed.

During an interview on 8/3/17 at 9:40 a.m. with the pharmacist it was revealed that doses of 450 mg or more of Lyrica had no added benefits or advantages and that the side effects would be the general side effects.

According to "Fundamentals of Nursing", Seventh Edition, 2009: by Perry and Potter, page 707, "Professional standards, such as the American Nurses Association's Nursing: Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication, 2. The right dose, 3. The right client, 4. The right route, 5. The right time, and 6. The right documentation.

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F 333	Continued From page 44 According to the Fundamentals of Nursing page 149, "When you care for a patient in your day-to-day nursing practice, one of the most crucial skills you bring to the bedside is your ability to administer medications...It is a highly technical skill that requires you to exercise wide-ranging knowledge, analytical skill, professional judgement and clinical expertise...the nurse must have a sound knowledge of drug terminology...and effects the drugs produce after they're inside the body..." Also, on page 172, "For some drugs you may need to measure the patient's therapeutic response before determining whether it's the right time to administer another dose,"(1). (1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia Medication Administration-Medication Basics pages 149 and 172. No further information was provided prior to exit. References: (1) Lyrica® ... Pregabalin is used to relieve neuropathic pain (pain from damaged nerves) that can occur in your arms, hands, fingers, legs, feet, or toes if you have diabetes or in the area of your rash If you have had shingles (a painful rash that occurs after infection with herpes zoster). It is also used to treat fibromyalgia (a long-lasting condition that may cause pain, muscle stiffness and tenderness, tiredness, and difficulty falling asleep or staying asleep). Pregabalin is used with other medications to treat certain types of seizures in people with epilepsy. Pregabalin is in a class of medications called anticonvulsants. It works by decreasing the number of pain signals that are sent out by damaged nerves in the body.	F 333		

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F 333	Continued From page 45 This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a605045.html (2) Atrial fibrillation -- An arrhythmia is a problem with the speed or rhythm of the heartbeat. Atrial fibrillation (AF) is the most common type of arrhythmia. The cause is a disorder in the heart's electrical system. This information was obtained from the following website: https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=Atrial+fibrillation+&commit=Search (3) Coronary artery disease (CAD) is the most common type of heart disease. It is the leading cause of death in the United States in both men and women. This information was obtained from the following website: https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=Coronary+artery+disease+&commit=Search	F 333		
F 431 SS=D	COMPLAINT DEFICIENCY 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide	F 431	F Tag 431 1)The medicine cart was locked once discovered that it had been unlocked and unattended by the Nurse on 08/02/17 to ensure that Resident #11 and #12 medications Were safe guarded. Insulin pens Removed from top of cart and Placed in the medication cart.	

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F 431	Continued From page 46 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431	2) The other medicine cart was checked to ensure that it was locked per policy. 3) Director of Clinical Services will provide education to licensed nurses on 08/30/2017on the safe guarding of medications in keeping medicine carts locked when not in full view during medication administration. Education will be provided monthly to ensure compliance. Management team will conduct observations of the medication cart when making rounds 5 x weekly to ensure that medication cart is locked per policy, any variances will be reported to the DCS, immediate correction and re-education will be completed as necessary.	

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F 431	Continued From page 47 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure medications were safely secured on one of 4 resident halls; the Gold hall. 1. While preparing and administering medications for Resident #11, LPN (licensed practical nurse) #2 failed to ensure medications in the medication cart, were secured from potential resident access on the Gold hall. LPN #2 went into the resident's room, leaving the medication cart unlocked. The medication cart was not in her line of sight. 2. While preparing and administering medications to Resident #12, RN (registered nurse) #1 failed to ensure medications in the medication cart, were secured from potential resident access on the Gold hall. RN #1 went into Resident #12's room to administer medications he prepared and left the medication cart unlocked. The medication cart was not in his line of sight; one resident and three (3) staff members were observed passing by the unlocked medication cart. 3. The facility staff failed to secure two insulin pens belonging to two different residents from potential resident and staff access on the Gold hall. Two residents and three staff members were observed passing by the unsecured medications lying on an isolation cart outside room 16.	F 431	4) The observations related to Medication carts not being locked will be discussed by the Executive Director during the QAPI meeting. For review and recommendations If needed to sustain substantial compliance. 5) Compliance date: 09/05/2017	

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The findings include:

1. Resident #11 was admitted to the facility on 7/20/17 with the diagnoses of but not limited to cellulitis of the left leg, depression, anxiety, peripheral vascular disease, chronic kidney disease, cancer of the submandibular gland, diabetes, high cholesterol, and high blood pressure. Due to the recent admission, an MDS (Minimum Data Set) had not yet been completed. The admission nursing assessment documented the resident was alert to person and place only, with some short and long term memory problems.

On 8/2/17 at 7:07 a.m., LPN #2 (Licensed Practical Nurse) was observed preparing and administering medications to Resident #11. She prepared the following medications:

- Atenolol [1] 100 mg (milligrams), 1 tab
- Glipizide ER [2] 10 mg, 1 tab
- Lisinopril [3] 5 mg, 1 tab
- Actos [4] 15 mg, 1 tab
- Vitamin D3 [5] 1000 units, 1 tab
- Ranexa [6] 500 mg, 1 tab

LPN #2 then went into the resident's room, leaving the cart unlocked. The cart was not in front of the door to the resident's room and in full view of the nurse. No residents were observed to pass near the cart.

On 8/3/17 at approximately 9:30 a.m., an interview was conducted with LPN #2 (Licensed Practical Nurse). She stated that when a medication cart is left unsupervised, the drawers should be locked, the MAR should be closed, and medications, needles, etc., should not be left on

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F 431	Continued From page 49 top of the cart. She stated that she did not realize that she had not securely locked the cart. A review of the facility policy for Medication Administration did not document any criteria for ensuring the medication cart was locked and secured when unsupervised. On 8/3/17 at approximately 2:00 p.m., the DON (Director of Nursing - Administrative Corporate Staff (ASM) #2) was made aware of the findings. No further information was provided by the end of the survey. "A client's environment includes all of the many physical and psychosocial factors that influence or affect the life and survival of that client. This broad definition of environment crosses the continuum of care for settings in which the nurse and client interact (e.g., the home, community center, school, clinic, hospital, and long-term care facility). Safety in health care settings reduces the incidence of illness and injury, shortens the length or treatment and/or hospitalization, improves or maintains a client's functional status, and increases the client's sense of well-being." Potter and Perry, Fundamentals of Nursing, 6th edition, page 959. From Fundamentals of Nursing, 7th edition, 2009; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 5: "Client safety is a priority in health care. You need to protect clients from physical and emotional injury by continually assessing for and eliminating safety hazards." References: [1] Atenolol is used alone or in combination with	F 431		

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other medications to treat high blood pressure. It also is used to prevent angina (chest pain) and improve survival after a heart attack. Information obtained from https://medlineplus.gov/druginfo/meds/a684031.html

[2] Glipizide ER is used along with diet and exercise, and sometimes with other medications, to treat type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood). Information obtained from https://medlineplus.gov/druginfo/meds/a684060.html

[3] Lisinopril is used alone or in combination with other medications to treat high blood pressure. It is used in combination with other medications to treat heart failure. Lisinopril is also used to improve survival after a heart attack. Information obtained from https://medlineplus.gov/druginfo/meds/a692051.html

[4] Actos is used with a diet and exercise program and sometimes with other medications, to treat type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood). Information obtained from https://medlineplus.gov/druginfo/meds/a699016.html

[5] Vitamin D3 helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and

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F 431	Continued From page 51 Immune systems. Information obtained from https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=vitamin+d&_ga=2.192500842.1377447934.1502114951-734861906.1502114951 [6] Ranexa is used alone or with other medications to treat chronic angina (ongoing chest pain or pressure that is felt when the heart does not get enough oxygen). Information obtained from https://medlineplus.gov/druginfo/meds/a606015.html 2. While preparing and administering medications for Resident #12, RN (registered nurse) #1 failed to ensure medications in the medication cart, were secured from potential resident access on the Gold hall. RN #1 went into Resident #12's room to administer medications he prepared and left the medication cart unlocked. The medication cart was not in his line of sight; one resident and three (3) staff members were observed passing by the unlocked medication cart. Resident #12 was admitted to the facility on 7/7/17 with the diagnoses of but not limited to: tendonitis of the right shoulder, gait and mobility weaknesses, osteoporosis, high blood pressure, high cholesterol, low back pain, and Parkinson's disease. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD	F 431		

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(Assessment Reference Date) of 7/14/17. The resident was coded as being cognitively intact in ability to make daily life decisions, scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.

On 8/2/17 at 7:07 a.m., RN #1 (Registered Nurse) was observed preparing and administering medications to Resident #12. He prepared the following medications:

Requip [1] 3 mg (milligrams), 1 tab (tablet)
Synthroid [2] 88 mcg (micrograms), 1 tab
Tylenol [3] 325 mg, 2 tabs

RN #1 then went into the resident's room, leaving the MAR (medication administration record) open on top of the medication cart, with the front side of the medication cart facing the hallway. The medication cart was not in RN #2's entire view of the sight; a majority of the medication cart was positioned to the side of the door, and was not in front of the door.

During administration of the above medications, the resident requested some cough medicine.

On 8/2/17 at 7:14 a.m., RN #1 returned to the medication cart, reviewed the MAR for an order for cough medicine and noted there wasn't any. He then went to the nurse's station to check the chart and obtain an order. RN #1 returned to the cart at 7:17 a.m.

On 8/2/17 at 7:19 a.m., RN #1 went back into Resident #12's room to administer the tussin [4] cough medication he prepared. He left the medication cart unlocked; one resident and 3 staff members were observed passing by the

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F 431	Continued From page 53 unlocked medication cart. On 8/3/17 at approximately 9:30 a.m., an interview was conducted with LPN #2 (Licensed Practical Nurse). She stated when a medication cart is left unsupervised, the drawers should be locked, the MAR should be closed, and medications, needles, etc., should not be left on top of the cart. A review of the facility policy for Medication Administration did not document any criteria for ensuring the medication cart was locked and secured when unsupervised. On 8/3/17 at approximately 2:00 p.m., the DON (Director of Nursing - Administrative Corporate Staff (ASM) #2) was made aware of the findings. No further information was provided by the end of the survey. References: [1] Requip is used to treat the symptoms of Parkinson's disease. Information obtained from https://medlineplus.gov/druginfo/meds/a698013.html [2] Synthroid is used to treat hypothyroidism. Information obtained from https://medlineplus.gov/druginfo/meds/a682461.html [3] Tylenol is used to treat mild to moderate pain. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html [4] Tussin is used to relieve chest congestion by	F 431		

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F 431	Continued From page 54 making it easier to cough up mucus and clear the airway. Information obtained from https://medlineplus.gov/druginfo/meds/a682494.html 3. The facility staff failed to secure two insulin pens belonging to two different residents from potential resident and staff access on the Gold hall. Two residents and three staff members were observed passing by the unsecured medications lying on an isolation cart outside room 16. An observation was made outside room 16 on the Gold hall on 8/3/17 at 8:15 a.m. A white plastic isolation cart was placed outside the room. The cart was not visible from inside the room. There was a clipboard on top of the cart and there were five insulin needles and two insulin pens containing insulin lying on the clipboard. There was no staff in sight. At 8:16 a.m. a staff member wheeled a resident past the unsecured medications, a few seconds later a resident ambulated independently past the unsecured medications. Between 8:16 a.m. and 8:19 a.m. three staff members walked past the unsecured medications. At 8:19 a.m. a nurse came out of room 16, put other medications on the clipboard and sanitized her hands. An interview was conducted with the nurse LPN (licensed practical nurse) #2 at that time. LPN #2 stated, "I have those (indicating the insulin pens) to give to other residents. I can see them from the room." A request was made for the nurse to demonstrate how she could maintain line of sight on the medications. LPN #2 walked into the room with her back to the door and approached the resident who was sitting in a wheelchair in the left hand corner of the room. There was no clear line of	F 431		

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sight from the resident's position to the isolation cart. ASM (administrative staff member) #2, the director of nursing was present during the conversation. When asked if it was the facility's practice to have two different resident's medications pulled from the medication cart, lying unsecured out of staffs the line of sight, ASM #2 stated, "No, that's not right." When asked what process the staff followed during medication administration, ASM #2 stated, "You only doing one patient's medication at a time. What if you grabbed the wrong one and gave the resident the wrong insulin." ASM #2 was asked if LPN #2 could maintain line of sight with the unsecured medications lying on the isolation cart outside room 16, when she was in the room caring for another resident. ASM #2 stated, "No, she couldn't, no that's just not safety. One of the patients could pick it up. Anyone could get their hands on it."

Review of the facility's policy titled Medications: Oral Administration Of" documented, "Policy: It is the policy that the resident can expect safe and accurate administration..."

A review of the facility policy for Medication Administration documented, in all capital letters, "PREPARE MEDICATION FOR ONLY ONE RESIDENT AT A TIME."

No further information was provided prior to exit.

"Make sure all medications are in locked containers in a room (e.g., a medication room) or are under constant surveillance." Potter and Perry, Fundamentals of Nursing, seventh edition, 2009, p. 703.

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F 441 SS=D	Continued From page 56 483.80(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:	F 441 F 441	F Tag 441 1) Nurse identified in 2567 was Re- educated by the DCS regarding following infection control practices for use of glucometers 08/02/17. 2) DCS completed observations of licensed nurses for following infection control practices . Based on observation findings licensed nurses re- educated by the DCS On proper sanitation of glucometers prior to using and after use for each resident requiring a glucometer check, and to only take one strip into room to use for that resident requiring check. 3) DCS to provide re-education to Licensed nurses on 08/30/2017 in regards to the policy/procedure for infection control as related to the use of glucometers DCS/Unit manager to observe Infection control practices during Medication pass observation monthly Follow up based on findings. .	

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F 441	Continued From page 57 (A) The type and duration of the isolation, depending upon the infectious agent or organism 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, clinical record review, and facility document review, it was determined that the facility staff failed to follow infection control practices to prevent the spread of infection and disease during medication administration for two of 6 residents in the medication administration observation; Residents #11 and #5. While preparing and administering medications to	F 441	4) The observation results will be discussed In the QAPI committee meetings The committee will review and make recommendations as needed to sustain substantial compliance 5) Compliance date: 09/05/2017	

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Resident #11 the facility staff (LPN [licensed practical nurse] #2) failed to sanitize the glucometer [1] before and after use; and laid the vial of test strips on the resident's bed. LPN #2 then then used the glucometer to obtain Resident #5's blood sugar reading, without sanitizing it first after having used it on Resident #11, and also took the vial of test strips into the room of Resident #5.

The findings include:

Resident #11 was admitted to the facility on 7/20/17 with the diagnoses of but not limited to: cellulitis of the left leg, depression, anxiety, peripheral vascular disease, chronic kidney disease, cancer of the submandibular gland, diabetes, high cholesterol, and high blood pressure. Due to the recent admission, an MDS (Minimum Data Set) had not yet been completed. The admission nursing assessment documented the resident was alert to person and place only, with some short and long term memory problems.

Resident #5 was admitted to the facility on 1/26/16 and readmitted on 7/28/17 with the diagnoses of but not limited to: sepsis, acute kidney failure, sleep apnea, large intestine cancer, morbid obesity, high cholesterol, depression with psychotic features, chronic pain syndrome, high blood pressure, overactive bladder, a colostomy, an artificial eye, and diabetes. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/13/17. The resident was coded as being cognitively intact in ability to make daily life decisions, scoring a 15

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out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring extensive assistance for bathing; supervision for hygiene, dressing, and transfers; was independent for eating; and was continent of bladder and had an ostomy for bowel.

On 8/2/17 at 7:07 a.m., LPN #2 (Licensed Practical Nurse) was observed preparing and administering medications to Resident #11. She prepared the following medications:

Atenolol [2] 100 mg (milligrams), 1 tab (tablet)
Glipizide ER (extended release) [3] 10 mg, 1 tab
Lisinopril [4] 5 mg, 1 tab
Actos [5] 15 mg, 1 tab
Vitamin D3 [6] 1000 units, 1 tab
Ranexa [7] 500 mg, 1 tab

LPN #2 was observed obtaining a blood glucose reading on Resident #11. She prepared the glucometer at the cart, and went into the room to administer medications and test the resident's blood sugar. The result of the blood sugar was 43 mg/dl (Milligrams per Deciliter). LPN #2 stated she felt that it was not a good sample and was going to re-test the resident. She returned to the medication cart, obtained additional lancets, and the vial of test strips. LPN #2 re-entered Resident #11's room with the vial of test strips, obtained a test strip from the vial, and then laid the vial of test strips on the resident's bed as she rechecked Resident #11's blood sugar. After administering the medications and washing her hands, LPN #2 returned the glucometer and vial of lancets to the drawer in the medication cart. She did not clean or sanitize the glucometer or

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the vial of test strips.

On 8/2/17 at 8:15 a.m., LPN #2 (Licensed Practical Nurse) then went to the room for Resident #5. She was observed preparing and administering medications for Resident #5. LPN #2 prepared the following medications:

Vitamin D 1000 units, 1 tab (tablets)
Aspirin [8] 81 mg (milligrams), 1 tab
Ferrous sulfate [9] 325 mg, 1 tab
Lanuts [10] 37 units (injection)
Metformin [11] 1000 mg, 1 tab
Diflucan [12] 100 mg, 2 tabs
Loratadine [13] 10 mg, 1 tab
Oxybutynin [14] 10 mg, 1 tab
Multivitamin [15], 1 tab
Novolog [16] 10 units (injection)

She then put on PPE (personal protective equipment, i.e., gown, gloves) and went into the room to administer medications to Resident #5. She did not sanitize the glucometer or vial of test strips prior to using them with Resident #5, after having used them with Resident #11.

On 8/3/17 at approximately 9:30 a.m., an interview was conducted with LPN #2 (Licensed Practical Nurse). She stated that she wipes down her cart and all the supplies at the beginning of her shift, and that the glucometer does not come in contact with the resident during testing, so she was not aware that it was necessary to sanitize it between each resident unless a resident is on isolation for an infection.

A review of the facility policy for Medication Administration did not document any criteria for

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F 441	Continued From page 61 cleaning multi-use supplies between each resident. A review of the owner's manual for the glucometer documented: "Important Safety Instructions Adhere to standard precautions when handling or using this device. All parts of the glucose monitoring system should be considered potentially infectious and are capable of transmitting blood-borne pathogens between patients and healthcare professionals.... The meter should be disinfected after use on each patient. This blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed.... The public health notification and standard practice guideline links are: "FDA Public Health Notification: Use of Fingerstick Devices on More than One Person Poses Risk for Transmitting Bloodborne Pathogens: Initial Communication" (2010) http://www.fda.gov/MedicalDevices/Safety/AlertsandNotices/ucm224025.htm "CDC Clinical Reminder: Use of Fingerstick Devices on More than One Person Poses Risk for Transmitting Bloodborne Pathogens" (2010) http://www.cdc.gov/Injectionsafety/Fingerstick-DevicesBGM.html.... NOTE:...Glucose meters in a clinical setting for testing multiple persons must be cleaned and disinfected between patients....' On 8/3/17 at approximately 2:00 p.m., the DON (Director of Nursing - Administrative Corporate	F 441		

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Staff (ASM) #2) was made aware of the findings. No further information was provided by the end of the survey.

According to the Centers for Disease Control (CDC): "Blood glucose meters are devices that measure blood glucose levels. Whenever possible, blood glucose meters should be assigned to an individual person and not be shared. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared. http://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html

References:

[1] A glucometer is a small device that reads the test strip and reports your blood sugar level. Information obtained from https://www.diabeteseducator.org/patient-resources/aade7-self-care-behaviors/aade7-self-care-behaviors-monitoring

[2] Atenolol is used alone or in combination with other medications to treat high blood pressure. It also is used to prevent angina (chest pain) and improve survival after a heart attack. Information obtained from https://medlineplus.gov/druginfo/meds/a684031.html

[3] Glipizide ER is used along with diet and

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exercise, and sometimes with other medications, to treat type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood). Information obtained from https://medlineplus.gov/druginfo/meds/a684060.html

[4] Lisinopril is used alone or in combination with other medications to treat high blood pressure. It is used in combination with other medications to treat heart failure. Lisinopril is also used to improve survival after a heart attack. Information obtained from https://medlineplus.gov/druginfo/meds/a692051.html

[5] Actos is used with a diet and exercise program and sometimes with other medications, to treat type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood). Information obtained from https://medlineplus.gov/druginfo/meds/a699016.html

[6] Vitamin D3 helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and immune systems. Information obtained from https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=vitamin+d&_ga=2.192500842.1377447934.1502114951-734861906.1502114951

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[7] Ranexa is used alone or with other medications to treat chronic angina (ongoing chest pain or pressure that is felt when the heart does not get enough oxygen). Information obtained from https://medlineplus.gov/druginfo/meds/a606015.html

[8] Aspirin is used to prevent heart attacks in people who have had a heart attack in the past or who have angina (chest pain that occurs when the heart does not get enough oxygen); to reduce the risk of death in people who are experiencing or who have recently experienced a heart attack; to prevent ischemic strokes (strokes that occur when a blood clot blocks the flow of blood to the brain) or mini-strokes (strokes that occur when the flow of blood to the brain is blocked for a short time) in people who have had this type of stroke or mini-stroke in the past. Aspirin will not prevent hemorrhagic strokes (strokes caused by bleeding in the brain). Aspirin is in a group of medications called salicylates. It works by stopping the production of certain natural substances that cause fever, pain, swelling, and blood clots. Information obtained from https://medlineplus.gov/druginfo/meds/a682878.html

[9] Ferrous sulfate provides the iron needed by the body to produce red blood cells. It is used to treat or prevent iron-deficiency anemia, a condition that occurs when the body has too few red blood cells because of pregnancy, poor diet, excess bleeding, or other medical problems. Information obtained from https://medlineplus.gov/druginfo/meds/a682778.html

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[10] Lanuts is a long-acting, man-made version of human insulin. Insulin glargine works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar. Information obtained from https://medlineplus.gov/druginfo/meds/a600027.html

[11] Metformin is used alone or with other medications, including insulin, to treat type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood). Information obtained from https://medlineplus.gov/druginfo/meds/a696005.html

[12] Diflucan is used to treat fungal infections, including yeast infections of the vagina, mouth, throat, esophagus (tube leading from the mouth to the stomach), abdomen (area between the chest and waist), lungs, blood, and other organs. Information obtained from https://medlineplus.gov/druginfo/meds/a690002.html

[13] Loratadine is used to temporarily relieve the symptoms of hay fever (allergy to pollen, dust, or other substances in the air) and other allergies. Information obtained from https://medlineplus.gov/druginfo/meds/a697038.html

[14] Oxybutynin is used to treat overactive bladder (a condition in which the bladder muscles contract uncontrollably and cause frequent urination, urgent need to urinate, and inability to

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F 441	Continued From page 66 control urination) control urgent, frequent, or uncontrolled urination in people who have overactive bladder (a condition in which the bladder muscles have uncontrollable spasms). Information obtained from https://medlineplus.gov/druginfo/meds/a682141.html [15] Multivitamin/mineral supplements contain a combination of vitamins and minerals. They sometimes have other ingredients, such as herbs. They are also called multis, multiples, or simply vitamins. Multis help people get the recommended amounts of vitamins and minerals when they cannot or do not get enough of these nutrients from food. Information obtained from https://medlineplus.gov/definitions/vitaminsdefinitions.html [16] Novolog is a short-acting, manmade version of human insulin. Insulin aspart works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar. Information obtained from https://medlineplus.gov/druginfo/meds/a605013.html	F 441		
F 465 SS=D	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465	F Tag 465 1)The 6 ceiling tiles that were stained were replaced on 08/3/2017 by the maintenance director.	

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residents, staff and the public.

(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview it was determined that the facility staff failed to provide a sanitary, and comfortable environment for residents, staff and the public on three of four resident hallways, (Gold, Red and Green halls).

Six brown stained ceiling tiles were observed on the Gold, Red and Green resident hallways of the facility.

The findings include:

A building tour was completed on 8/3/17 at 1:20 p.m. with OSM (other staff member) #4, the director of maintenance. Six brown stained ceiling tiles were observed:
Outside room 22 there were two ceiling tiles with large brown stains; outside room 26 there was a brown stain approximately 5 inches round on the ceiling tile; outside the oxygen storage closet a large brown stain was observed on the ceiling tile; outside the "staff only" closet there was a stained ceiling tile and outside room 43 there was a stained ceiling tile.

An interview was conducted on 8/3/17 at 1:35 p.m. with OSM (other staff member) #4. OSM #4 stated, "I just got some new tiles in and I'll replace them. I was doing some work up there (indicating the stained tile outside the oxygen storage

F 465

2)Environmental rounds completed by the Executive Director On 08/04/2017 to observe if any more ceiling tiles were stained, none found.

3) The maintenance director was Educated on 08/4/2017 regarding stained ceiling tiles to be replaced as soon as noted to be stained. Executive Director to observe for any stained ceiling tiles during environmental rounds in the facility monthly.

4)The results of the environmental rounds will be taken to the QAPI meeting for review and recommendations as needed to sustain substantial compliance.

5) Compliance date: 09/05/2017

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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; (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;	F 514	F Tag 514 1)Resident #4's Medical Record is unable to be corrected however resident's medical record going forward will be maintain accurately .Resident's #7 clinical documentation was removed on 08/2/17 and placed in the correct medical record. 2)Quality review completed by DCS/designee of medical record s for current Residents for completeness. Incomplete records corrected if possible, per regulatory standards. Quality review conducted by DCS/designee on current resident's medical records to ensure that residents records are in the correct residents clinical record.	

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(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 observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure a complete and accurate clinical record for two of 17 residents in the survey sample; Residents #4 and #7.

1. a. The facility staff failed to document a pain assessment for Resident #4, including measurable criteria (a pain scale), quality descriptors of pain, and/or any non-pharmacological interventions attempted prior to the administration of pain medication, and/or post-administration follow up assessment on 22 occasions in April 2017, 20 occasions in May 2017, 17 occasions in June 2017, and 9 occasions in July 2017.

b. The facility staff failed to document the physician ordered weekly vital signs in Resident #4's clinical record for 2 weeks in April 2017, and 4 weeks each for the months of May 2017, June 2017, and July 2017.

2. Resident # 7's clinical record contained documents that belonged to another resident.

The findings include:

1.a. Resident #4 was admitted to the facility on

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3) Education provided to clinical staff by the DCS on 08/30/17, in regards to complete and accurate documentation. Education given to the Medical records Clerk by the Executive Director on 08/04/17 on ensuring that the correct record is filed in the correct resident's clinical record.

10 % of current resident's clinical records to be reviewed by the DCS/ designee monthly to ensure records are complete and accurate. Staff will be re-educated if indicated.

4) The plan of correction and Clinical record reviews will be Discussed by the Executive Director during the QAPI Committee Meeting Monthly The Committee will recommend needed revisions to the plan to sustain substantial compliance.

5) Compliance date: 09/05/2017

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9/9/02 and readmitted most recently on 1/13/17 with the diagnoses of but not limited to cerebral palsy, insomnia, low blood pressure, hypertonia spasticity, depression, arthritis, anxiety, paranoia, delusional disorder, and osteoporosis.

The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/16/17. Resident #4 was coded as being moderately impaired in ability to make daily life decisions, scoring an 11 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #4 was coded as requiring total care for bathing; extensive care for transfers, dressing, and hygiene; supervision for eating; and as incontinent of bowel and bladder.

A review of the clinical record revealed an order for Hydrocodone-Acetaminophen (Norco) 5/325 mg (milligrams), take 1 tab every 6 hours as needed for pain. The date of this order was updated monthly via 30 day prescription renewal.

A review of the clinical record revealed the MARs (Medication Administration Record) for April 2017, May 2017, June 2017, and July 2017. This review revealed that the resident was administered the Norco on 29 occasions in April 2017, 20 occasions in May 2017, 17 occasions in June 2017, and 9 occasions in July 2017. Of these administrations, 22 of the 29 times in April 2017, all 20 of the administrations in May 2017, all 17 of the administrations in June 2017, and all 9 of the administrations in July 2017 did not contain part or all of the necessary documentation for pain management. Missing components included pre-administration assessment of the resident's pain; non-pharmacological interventions attempted,

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F 514	Continued From page 71 and follow up assessment of the resident's pain. On 8/3/17 at 3:20 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #11. She stated that she does ask the resident about the location and intensity of her pain, and that non-pharmacological interventions are attempted. LPN #11 stated she follows up with the resident afterwards. She stated that the assessment and follow up should be documented on the back of the MAR and on the pain flow sheet. LPN #11 stated, "We don't always document like we should." On 8/3/17 at 3:29 p.m., an interview was conducted with RN (Registered Nurse) #7. She stated that she asks the resident to rate her pain on a scale 0-10, location of the pain, and offers non-pharmacological interventions. When asked about documenting this in the clinical record, RN #7 stated, "I don't think I did." On 8/3/17 at approximately 2:00 p.m., the DON (Director of Nursing - Administrative Corporate Staff (ASM) #2) was made aware of the findings. No further information was provided by the end of the survey. References: [1] Norco is hydrocodone in combination with acetaminophen and is used to relieve moderate-to-severe pain. Information obtained from https://medlineplus.gov/druginfo/meds/a601006.html	F 514		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 72 b. The facility staff failed to document the physician ordered weekly vital signs in Resident #4's clinical record for 2 weeks in April 2017, and 4 weeks each for the months of May 2017, June 2017, and July 2017. Review of the clinical record revealed an order dated 11/11/16 for "Weekly Vitals every Wednesday." A review of the MAR revealed that staff failed to document the physician ordered weekly vital signs in the clinical record for 2 weeks in April 2017, and 4 weeks each for the months of May 2017, June 2017, and July 2017. On 8/3/17 at 11:15 a.m., in an interview with LPN #4, she stated they (vital signs) should be documented in the record. LPN #4 stated many times, they (vital signs) will be documented on a unit logbook which contains information for other residents as well. LPN #4 stated the unit logbook is not part of the clinical record, and they (vital signs) would not get logged into each resident's clinical record. On 8/3/17 at approximately 2:00 p.m., the DON (Director of Nursing - Administrative Corporate Staff (ASM) #2) was made aware of the findings. No further information was provided by the end of the survey. According to "Fundamentals of Nursing Made Incredibly Easy Lippincott Williams and Wilkins, Philadelphia PA page 23: Nursing documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the health care team. Unless the content of documentation provides an	F 514		

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F 514	Continued From page 73	F 514		

accurate depiction of patient and family care, quality of care may not be possible. Many nurses do not realize that what they document or fail to record can produce an enormous effect on the care that is provided by other members of the health care team."

2. Resident # 7's clinical record contained documents that belonged to another resident.

Resident # 7 was admitted to the facility on 1/3/05 and most recently readmitted on 11/22/16 with diagnoses that included but were not limited to: anemia, osteoporosis (1), depression, gastroesophageal reflux disease (2), anxiety, and bipolar disorder (3). Resident # 7's most recent MDS (minimum data set) a quarterly assessment with an ARD (assessment reference date) of 7/10/17 coded the resident as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, indicating that Resident # 7 was cognitively intact.

During a review of Resident # 7's clinical record, documents belonging to another resident were noted to be in Resident # 7's record.

During an interview on 8/2/17 at 10:20 a.m. with ASM (Administrative staff member) # 1, the administrator, this concern was shared. ASM # 1 stated that the 11 to 7 shift misfiled the documents in the wrong record. At this time a request for the facility policy on clinical records was requested.

The facility policy "Clinical/Medical Records MR-195" was provided by ASM # 2, the Director of Nurses on 8/3/17 at 8:30 a.m. This policy documented the following under "Policy ...Clinical

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records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care. The clinical record shall contain - information to identify the resident clearly; a record of the resident's assessments; the plan of care and services; the results of pre-admission screening; and progress notes which indicated change toward achieving the care plan objectives. In addition, the resident's clinical record shall be readily accessible and systematically organized to facilitate retrieving and compiling information. All information contained in the resident's clinical record, regardless of the form or storage method, shall be considered confidential. The facility has the property right to the clinical record, but the resident has the protected right of information. The propose of the clinical record is to document the course of the resident's plan of care and to provide a medium of communication among health care professionals involved in this care ..."

According to "Fundamental Nursing Skills and Concepts": Eighth edition, Chapter 3, pg. 36 read: "Each healthcare setting requires accurate and complete documentation: The medical record is a legal document....Records must be timely, objective, accurate, complete and legible..."

No further information was provided prior to exit.

References:

(1) Osteoporosis -- Makes your bones weak and more likely to break. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosi

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F 514	Continued From page 75 s.html. (2) Gastroesophageal reflux disease -- Stomach contents to leak, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (3) Bipolar disorder -- also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out daily tasks. Symptoms of bipolar disorder can be severe. They are different from the normal ups and downs that everyone goes through from time to time. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0024571/	F 514		