FREDERICKSBURG
HEALTH AND REHAB

3900 Plank Road
Fredericksburg, VA 22407
phone 540 786 5589
fax 540 786 5599
fredericksburgrehab.com

July 17, 2017

Wietske G. Weigel-Delano, LTC Supervisor
Department of Health
Office of Licensure & Certification
9960 Maryland Drive, Suite 401
Henrico, Virginia 23233-1485

Attention: Wietske G. Weigel-Delano:

Please find the completed Plan of Correction. This Plan of Correction being submitted does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law. The facility alleges compliance with the submission of this plan as of July 21, 2017.

If you have any questions, please don't hesitate to contact me at the facility (540) 786-8351 or email me at trocquemore@fredericksburgrehab.com

Sincerely,

Tanya Rocquemore LNHA

Tanya Rocquemore, RN MHA LNHA
Administrator

Encl: Plan of Correction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	R-C 06/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 04/25/17 through 04/28/17, was conducted 06/19/17 through 06/21/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. The census in this 177 certified bed facility was 110 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents 101 through 114).	{F 000}		
{F 281} SS=D	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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for the transcription and clarification of a physician order for Resident #107. The facility staff failed to correctly transcribe the physician order for Florinef and further failed to clarify the order for Resident #107.	{F 281}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tanya Rocquemore LNHA — TITLE: Administrator — (X6) DATE: 7/17/17

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

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The findings include:

Resident #107 was admitted to the facility on 11/17/16 with a recent readmission on 5/2/17 with diagnoses that included but were not limited to: diabetes, chronic pain, muscle weakness, anxiety, bipolar disorder (a mental disorder characterized by episodes of mania and depression (1)), and high blood pressure.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 5/8/17, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score indicating that the resident was capable of making daily cognitive decisions. The resident was coded as requiring supervision or as being independent with set up assistance or one person assistance for all of her activities of daily living.

The physician order dated, 6/8/17, documented, "Fludrocortisone Acetate* Tablet; give 0.1 mg (milligram) by mouth three times a day related to PURE HYPERCHOLESTEROLEMIA (higher than normal amounts of cholesterol in the blood (2))."

*Fludrocortisone Acetate, also known as Florinef, is indicated as partial replacement therapy for primary and secondary adrenocortical insufficiency in Addison's disease and for the treatment of salt-losing adrenogenital syndrome. (3)

The June 2017 MAR (medication administration record) documented, "Fludrocortisone Acetate* Tablet; give 0.1 mg (milligram) by mouth three times a day related to PURE HYPERCHOLESTEROLEMIA." The medication

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1. Resident #107 medication administration record was corrected on June 20, 2017 to indicate hyponatremia as the correct diagnosis for florinef.
2. The Director of Nursing/designee to re-educate nursing staff on professional standards of quality to include transcribing orders. Newly hired nursing staff will be educated during orientation.
3. The Director of Nursing/RNAC/designee will review physician orders with accurate diagnosis three times a week times four weeks, twice a month, and then monthly times one month.
4. The Director of Nursing/designee will report audit results monthly to the Quality Assurance Performance Improvement committee to ensure continued compliance and/or revision.

Completion date: 7-21-17

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was documented as having been given every day as ordered. A "Pain Level" rating was documented above each dose.

The nurse's note dated, 6/8/17 at 2:49 p.m. documented, "Lab (laboratory) called and stated critical sodium lab at 124*, called MD (medical doctor) and left message. Pending call back for new orders."

*Normal sodium levels in the blood are 137 to 142 mEq/L (milliequivalents per liter). (4)

The nurse's note dated, 6/8/17 at 2:54 p.m. documented in part: "MD called back, new orders; Florinef 0.1 mg po (by mouth) TID (three times a day)."

The laboratory test results dated, 6/8/17 documented the resident's sodium level as 129 mEq/L. On the laboratory test results dated, 6/8/17 was documented in pen the following: "Florinef 0.1 mg PO TID."

The comprehensive care plan dated, 5/24/16 and revised on 5/29/17, documented in part, "Focus: Potential for alteration in Hydration related to: diuretic use and h/o (history of) c/o (complaints of) nausea." The "Interventions" documented in part, "Obtain and monitor lab/diagnostic work per physician order. Report results to physician and follow up as indicated."

An interview was conducted with LPN (licensed practical nurse) #3 on 6/20/17 at 2:04 p.m. When asked how verbal physician orders for medications are handled, LPN #3 stated, "When we get an order, we have to enter it in the computer under telephone order. We print it out

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and then the doctor signs it and it (the order) goes in the chart." When asked if she knew what Florinef/Fludrocortisone is used for, LPN #3 stated, "I believe it's for her sodium because it was low." LPN #3 was asked to review the physician order and MAR for Resident #107. When asked if the physician order for Florinef should have been clarified, LPN #3 stated, "Yes, the person who entered that into the computer picked the wrong diagnosis from the drop down box of diagnoses." The paper chart for Resident #107 was reviewed with LPN #3 and the doctor's book was reviewed. The order for the Florinef could not be located.

An interview was conducted with administrative staff member (ASM) #4, the attending physician for Resident #107, on 6/20/17 at 2:45 p.m. When asked what Florinef is used for, ASM #4 stated, "It's used to treat hyponatremia (lower than normal concentration of sodium in the blood (5)), it's used to bump up the sodium levels without extremely restricting the person's fluid intake. This surveyor read the physician order for Florinef that documented it was for hypercholesterolemia, to ASM #4. ASM #4 stated, "I can't check everything they type in the computer. It's definitely a problem there. Whenever she (Resident #107) gets pneumonia, her sodium levels drop. She's just getting over that now."

An interview was conducted with ASM #2, the director of nursing, on 6/20/17 at 4:35 p.m., regarding physician verbal orders for medications. ASM #2 stated, "The nurse types it in the computer and prints it out for the doctor to sign." When asked if a nurse is allowed to write an order on the laboratory test results, ASM #2

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stated, "No." When asked if it was written on the laboratory test results paper, is that considered an order, ASM #2 stated, "No, Ma'am." ASM #2 was asked if she was familiar with the drug Florinef/Fludrocortisone. ASM #2 stated, "It's a cortisone, but I am not that familiar with it." When shown the order for the Florinef/Fludrocortisone, ASM #2 was asked if the diagnosis of hypercholesterolemia was correct, ASM #2 stated, "No, I wouldn't think so." When asked if that order should have been clarified, ASM #2 stated, "Yes." When asked what standard of practice the facility follows, ASM #2 stated, "Lippincott." A policy on transcribing and clarifying orders was requested.

An interview was conducted with RN (registered nurse) #2, the nurse who transcribed the order for the Florinef on 6/21/17 at 11:25 a.m. When asked where the printed copy of the order was, RN #2 stated, "I had printed it off and faxed it to the pharmacy." RN #2 presented a copy of the typed order dated, 6/8/17 with a time stamp of 2:59 p.m. RN #2 stated, I had the pharmacy send me this copy, I had done it but I don't know where it went. When asked if it is acceptable to write a physician order on the laboratory test results sheet, RN #2 stated, "I had asked another nurse about where to write the order and she instructed me to write it there." When asked if the diagnosis is correct for the medication, RN #2 stated, "I must have hit the wrong diagnosis on the drop down list."

According to "Fundamentals of Nursing- Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order

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carefully, concentrate on copying it correctly, check it when you're finished.

The administrator and ASM #2 were made aware of the above findings on 6/20/17 at 5:03 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman, page 73.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman, page 281
(3) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=2cd3965d-cab9-a97c-db61-7d03ced154f3
(4) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/books/NBK306/
(5) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman, page 285.

{F 282} SS=D 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN {F 282}

(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.
This REQUIREMENT is not met as evidenced by:

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Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow the written plan of care for two of 14 residents in the survey sample, Residents #113 and #102.

1. The facility staff failed to follow the written care plan for the administration of oxygen to Resident #113.

2. The facility staff failed to follow Resident # 102's written plan of care for the administration of oxygen.

The findings include:

1. Resident #113 was admitted to the facility on 3/10/17 with a recent readmission on 5/13/17 with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease - general term used for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), high blood pressure, depression, diabetes, obesity, blindness in right eye, heart disease, arthritis of knees, and muscle weakness.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/13/17, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating she was capable of making cognitive daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she was coded as requiring supervision after set up assistance was provided. In Section O -

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1. Resident #113 oxygen flow rate was adjusted according to the care plan. Resident #102 was assessed and orders clarified to read oxygen at 2L via nasal cannula continuously may remove for short periods of time.

2. The Director of Nursing/designee will review current residents receiving oxygen to ensure adherence to their written plan of care. The Director of Nursing/designee will re-educate the licensed nurses on following the written plan of care. Newly hired nursing staff will be educated during orientation.

7-21-17

3. The Director of Nursing/designee will randomly audit residents receiving oxygen according to their written care plan weekly times four weeks and then monthly times two months.

4. The Director of Nursing/designee will report the audits monthly to the Quality Assurance Performance Improvement committee to ensure continued compliance and/or revision.

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Special Treatments, Procedures and Problems, the resident was coded as receiving oxygen while a resident at the facility.

The comprehensive care plan dated, 3/12/17, documented in part, "Alteration in Respiratory Status due to Chronic Obstructive Pulmonary Disease." The "Interventions" documented in part, "Administer oxygen as needed per physician order. Monitor oxygen saturations on room air and/or oxygen. Monitor oxygen flow rate and response."

The physician order dated, 5/31/17, documented, "Oxygen on via n/c (nasal cannula) @ (at) 3 L/min (may remove for short periods of time) every shift related to chronic obstructive pulmonary disease."

Observation was made of Resident #113 on 6/20/17 at 7:58 a.m. Resident #113 was in bed, with her oxygen on via a nasal cannula. The oxygen flow rate on the concentrator was set at 4 L/min (liters per minute). Resident #113 was asleep. At 9:13 a.m. the oxygen flow rate was again observed set at 4 L/min.

An interview was conducted with RN (registered nurse) #3 on 6/20/17 at 1:50 p.m. When asked the purpose of the care plan, RN #3 stated, "It's the essential care that we provide. It's what we do to take care of them (the residents). It's their plan of care." When asked should the care plan be followed, RN #3 stated, "Yes."

An interview was conducted with LPN (licensed practical nurse) #3 on 6/20/17 at 2:04 p.m. When asked the purpose of the care plan, LPN #3 stated, "It's how we know how to take care of the residents and should be follow it according to the

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resident's diagnoses and needs."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 6/20/17 at 4:35 p.m. When asked the purpose of the care plan, ASM #2 stated, "It's to drive your plan of care. It's how we take care of the resident." When asked if it should be followed, ASM #2 stated, "Yes."

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care.

The administrator and ASM #2 were made aware of the above findings on 6/20/17 at 5:03 p.m.

The policy presented for following the care plan did not address following the plan of care.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman, page 124
2. The facility staff failed to follow Resident # 102's written plan of care for the administration of oxygen.

Resident # 102 was admitted to the facility on 06/09/17 with diagnoses that included but were not limited to: heart disease (1), heart failure,

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shortness of breath, diabetes mellitus (2), sleep apnea (3), anemia (4) and cancer of the intestine.

Resident # 102's most recent MDS (minimum data set); an admission assessment was not due at the time of survey. Review of the clinical record for Resident # 102 revealed a nursing admission assessment dated 06/09/17. Further review of the nursing admission assessment documented Resident # 102 was moderately impaired of cognition for making daily decisions.

An observation conducted on 06/20/17 at 7:45 a.m. revealed Resident # 102 was sitting up in her bed and had finished eating breakfast. Further review of the resident's room revealed the nasal cannula (5) attached to the oxygen tubing, was wrapped around the upper bed rail uncovered. Resident # 102 was not observed receiving oxygen.

An observation conducted on 06/20/17 at 9:15 a.m. revealed Resident # 102 was sitting up in her bed. Further review of the resident's room revealed the nasal cannula attached to the oxygen tubing, was wrapped around the upper bed rail uncovered. Resident # 102 was not observed receiving oxygen.

An observation conducted on 06/20/17 at 10:50 a.m. revealed Resident # 102 was sitting up in her wheelchair in the therapy department. Resident # 102 was engaged with exercises with a therapist. Further observation of Resident # 102 revealed a portable oxygen tank on the back of Resident # 102's wheelchair. Resident # 102 was not observed receiving oxygen.

An observation conducted on 06/20/17 at 12:45

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p.m. revealed Resident # 102 was sitting up in her wheelchair in in her room eating lunch. Further observation of Resident # 102 revealed a portable oxygen tank on the back of Resident # 102's wheelchair. Resident # 102 was not observed receiving oxygen.

The physician's order dated 06/13/2017 for Resident # 102 documented, "2L (two liters per minute) O2 (oxygen) via (by) NC (nasal cannula) continuous."

The care plan for Resident # 102 dated 06/10/2017 documented, "Focus. Alteration in Respiratory Status Due to Congestive Heart Failure, Requires Oxygen, History of Pneumonia, risk for fatigue due to shortness of breath, risk of shortness of Breath, resident is on fluid restrictions." Under "Interventions" it documented, "Administer oxygen as needed per Physician order. Monitor oxygen saturation on room air and/or oxygen. Monitor oxygen flow rate and response. Date Initiated: 06/10/2017."

On 06/20/17 an interview was conducted at 2:15 p.m. with RN (registered nurse) # 3. When asked to describe the purpose of a resident's care plan, RN # 3 stated, "It has the individualized care with interventions to be followed." After reviewing the care plan dated 06/10/2017 for resident # 102 RN # 3 was asked if the care plan was followed for the administration of oxygen. RN # 3 stated, "No."

On 06/20/17 at 4:30 p.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. When asked to describe the purpose of a resident's care plan, ASM # 2 stated, "It directs the plan of care."

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On 06/20/17 at approximately 5:00 p.m. ASM # 1, the administrator, and ASM # 2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:

(1) There are many different forms of heart disease. The most common cause of heart disease is narrowing or blockage of the coronary arteries, the blood vessels that supply blood to the heart itself. This is called coronary artery disease and happens slowly over time. It's the major reason people have heart attacks. Other kinds of heart problems may happen to the valves in the heart, or the heart may not pump well and cause heart failure. Some people are born with heart disease. This information was obtained from the website: https://medlineplus.gov/heartdiseases.html.

(2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(3) Sleep apnea is a common disorder that causes your breathing to stop or get very shallow. Breathing pauses can last from a few seconds to minutes. They may occur 30 times or more an hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html.

(4) Low iron. This information was obtained from

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the website:
https://www.nlm.nih.gov/medlineplus/anemia.html
.

(5) Tubing used to deliver oxygen at levels from 1 to 6 L/min. The nasal prongs of the cannula extend approx. 1 cm into each naris and are connected to a common tube, which is then connected to the oxygen source. It is used to treat conditions in which a slightly enriched oxygen content is needed, such as emphysema. The exact percentage of oxygen delivered to the patient varies with respiratory rate and other factors. This information was obtained from the website:
http://medical-dictionary.thefreedictionary.com/nasal+cannula.

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

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

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

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

(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with

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1. Resident #113 oxygen flow rate was adjusted according to the care plan. Resident ##113 oxygen tubing was placed in a protective storage bag. Resident #102 physician orders for oxygen were clarified to allow removal for short periods of time. Resident #102 oxygen tubing was placed in a protective storage bag.
2. The Director of Nursing and nursing staff assessed current residents receiving oxygen to ensure administration per physician orders and tubing properly stored.
3. The Director of Nursing/designee will re-educate nursing staff on treatment care for special needs and proper storage of respiratory equipment. The Director of Nursing/designee will randomly audit residents receiving oxygen to ensure administration per physician orders and properly stored tubing weekly times four weeks and then monthly times two months.
4. The Director of Nursing/designee will report the audit results monthly to the Quality Assurance Performance Improvement committee for continued compliance and/or revision.

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professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

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

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

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it

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was determined that the facility staff failed to administer oxygen per the physician order and store oxygen equipment in a sanitary manner for two of 14 residents in the survey sample, Residents #113 and #102.

1. a. The facility staff failed to administer oxygen to Resident #113 per the physician order.

1. b. The facility staff failed to store oxygen tubing per the physician order for Resident #113.

2. a. The facility staff failed to keep Resident # 102's oxygen nasal cannula (plastic tube placed in the nostrils to deliver oxygen) covered when not in use.

2. b. The facility staff failed to administer Resident # 102's oxygen according to the physician's orders.

The findings include:

1. a. Resident #113 was admitted to the facility on 3/10/17 with a recent readmission on 5/13/17 with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease - general term used for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), high blood pressure, depression, diabetes, obesity, blindness in right eye, heart disease, arthritis of knees, and muscle weakness.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/13/17, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating she

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was capable of making cognitive daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she was coded as requiring supervision after set up assistance was provided. In Section O - Special Treatments, Procedures and Problems, the resident was coded as receiving oxygen while a resident at the facility.

The physician order dated, 5/31/17, documented, "Oxygen on via n/c (nasal cannula) @ (at) 3 L/min (may remove for short periods of time) every shift related to chronic obstructive pulmonary disease."

1. Resident #113 was admitted to the facility on 3/10/17 with a recent readmission on 5/13/17 with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease - general term used for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), high blood pressure, depression, diabetes, obesity, blindness in right eye, heart disease, arthritis of knees, and muscle weakness.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/13/17, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating she was capable of making cognitive daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she was coded as requiring supervision after set up assistance was provided. In Section O - Special Treatments, Procedures and Problems, the resident was coded as receiving oxygen while

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a resident at the facility.

The physician order dated, 5/31/17, documented, "Oxygen on via n/c (nasal cannula) @ (at) 3 L/min (may remove for short periods of time) every shift related to chronic obstructive pulmonary disease."

Observation was made of Resident #113 on 6/20/17 at 7:58 a.m. Resident #113 was in bed, with her oxygen on via a nasal cannula. The oxygen flow rate on the concentrator was set at 4 L/min (liters per minute). Resident #113 was asleep. At 9:13 a.m. the oxygen flow rate was again observed set at 4 L/min.

The comprehensive care plan dated, 3/12/17, documented in part, "Alteration in Respiratory Status due to Chronic Obstructive Pulmonary Disease." The "Interventions" documented in part, "Administer oxygen as needed per physician order. Monitor oxygen saturations on room air and/or oxygen. Monitor oxygen flow rate and response."

An interview was conducted with LPN (licensed practical nurse) #3 at 9:15 a.m. LPN #3 was asked to view Resident #113's oxygen concentrator for the oxygen flow rate settings. LPN #3 reviewed Resident #113's physician orders on the computer. LPN #3 was asked what Resident #113's oxygen flow rate should be. LPN #3 stated, "3 L/min." LPN #3 then entered Resident #113's room and observed the concentrator. When asked what flow rate the oxygen concentrator was set at, LPN #3 stated, "It looks like 4 L/min." LPN #3 proceeded to check the resident's oxygen level and assess the resident.

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An interview was conducted with LPN #2, the unit manager, on 6/20/17 at 1:35 p.m., regarding how staff set the prescribed oxygen flow rates for residents'. LPN #2 stated, "Sometimes nurses don't understand how to put the ball (on the concentrator) right." When asked where the ball should be for the prescribed rate, LPN #2 stated, "The line for the prescribed rate should be through the center of the ball." When asked if nurses should check the oxygen concentrator flow rate settings, LPN #2 stated, "Yes, they should check it each time they enter the room."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 6/20/17 at 4:35 p.m., regarding administering oxygen to residents as prescribed by the physician. ASM #2 stated, "They should check the order, then check the concentrator to ensure its set at the prescribed rate." When asked if there is a concern if a resident receives too much oxygen, ASM #2 stated, "Yes, I was taught in nursing school that too much can be dangerous in certain patients."

The administrator and ASM #2 were made aware of the above findings on 6/20/17 at 5:03 p.m. A copy of the policy related to oxygen administration was requested.

The facility presented a document on 6/21/17 at approximately 10:30 a.m. The document was from "Fundamentals of Nursing - Lippincott." It documented in part, "Oxygen Administration - Implementation: Verify the doctor's order for the oxygen therapy...help place oxygen delivery device on the patient. Make sure it fits properly and is stable...Nursing Alert: Never administer oxygen by nasal cannula at more than 2L/minute

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to a patient with chronic lung disease unless you have a specific order to do so. Some patients with chronic lung disease are dependent on a state of hypercapnia (excess carbon dioxide in the blood (2)) and hypoxia (inadequate amounts of available oxygen in the blood (3)) to stimulate their respirations and supplemental oxygen could cause them to stop breathing. However, long term oxygen therapy of 12 - 17 hours daily may help patients with chronic lung disease sleep better, survive longer and experience a reduced incidence of pulmonary hypertension."

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

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman, page 124.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman, page 281.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman, page 286

1. b. During the initial tour of the facility on 6/19/17 at 3:15 p.m. Resident #113 was not in her room. Resident #113's oxygen nasal cannula was observed wrapped around the upper side

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rail. The nasal cannula was not in a bag. A bag was attached to the oxygen concentrator. On 6/19/17 at 5:22 p.m. Resident #113's room was again observed, she was not in the room. The oxygen nasal cannula and tubing was again observed wrapped around the side rail and not stored in a bag. The tubing was dated 6/14/17.

An interview was conducted with Resident #113 on 6/20/17 at 9:13 a.m. Resident #113 was in bed with her oxygen in use. When asked if she removes her own oxygen tubing and puts in on the side rail, Resident #113 stated, "No, they move it from the concentrator to the tank when I'm up in the wheelchair. I don't do anything with the tubing."

An interview was conducted with LPN (licensed practical nurse) #2, the unit manager, on 6/20/17 at 1:35 p.m. When asked where oxygen tubing and cannulas are stored when not in use, LPN #2 stated, "They should be stored in a bag with the resident's name, date and room number."

An interview was conducted with RN (registered nurse) #3, on 6/20/17 at 1:50 p.m. When asked where oxygen tubing and cannulas are stored when not in use, RN #3 stated, "In a bag on the concentrator."

An interview was conducted with LPN #3, on 6/20/17 at 2:04 p.m. When asked where oxygen tubing and nasal cannulas are stored when not in use, LPN #3 stated, "In a bag on the concentrator."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 6/20/17 at 4:35 p.m. When asked where

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oxygen tubing and nasal cannulas are stored when not in use, ASM #2 stated, "It is stored in a bag on the concentrator. We have a few residents that wrap it around things."

The administrator and ASM #2 were made aware of the above findings on 6/20/17 at 5:03 p.m.

The policy presented by ASM #2 on 6/21/17 at approximately 10:30 a.m. did not address the storage of oxygen equipment.

"The humidification system may be a source of bacteria. Pseudomonas aeruginosa is frequently the organism involved. Oxygen delivery equipment such as cannulas and masks can also harbor organisms." (Ignatavicius, D. & Workman, L. (2002) Medical Surgical Nursing, Critical Thinking for Collaborative Care, 4th edition. (p.492) Philadelphia, Pennsylvania: W. B. Saunders Company.)

No further information was provided prior to exit.

2a. The facility staff failed to keep Resident # 102's oxygen nasal cannula (plastic tube placed in the nostrils to deliver oxygen (5)) covered when not in use.

Resident # 102 was admitted to the facility on 06/09/17 with diagnoses that included but were not limited to: heart disease (1), heart failure, shortness of breath, diabetes mellitus (2), sleep apnea (3), anemia (4) and caner of the intestine.

Resident # 102's most recent MDS (minimum data set), an admission assessment was nor due

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at the time of survey. Review of the clinical record for Resident # 102 revealed a nursing admission assessment dated 06/09/17. Further review of the nursing admission assessment documented Resident # 102 was moderately impaired of cognition for making daily decisions.

An observation conducted on 06/20/17 at 7:45 a.m. revealed Resident # 102 was sitting up in her bed and had finished eating breakfast. Further review of the resident's room revealed the nasal cannula attached to the oxygen tubing, was wrapped around the upper bed rail uncovered.

An observation conducted on 06/20/17 at 9:15 a.m. revealed Resident # 102 was sitting up in her bed. Further review of the resident's room revealed the nasal cannula attached to the oxygen tubing, was wrapped around the upper bed rail uncovered.

The physician's order dated 06/13/2017 for Resident # 102 documented, "2L (two liters per minute) O2 (oxygen) via (by) NC (nasal cannula) continuous."

The care plan for Resident # 102 dated 06/10/2017 documented, "Focus. Alteration in Respiratory Status Due to Congestive Heart Failure, Requires Oxygen, History of Pneumonia, risk for fatigue due to shortness of breath, risk of shortness of Breath, resident is on fluid restrictions." Under "Interventions" it documented, "Administer oxygen as needed per Physician order. Monitor oxygen saturation on room air and/or oxygen. Monitor oxygen flow rate and response. Date Initiated: 06/10/2017."

On 06/20/17 an interview was conducted at 1:40

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p.m. with LPN (licensed practical nurse) # 2, unit manager. When asked about the procedure for storing a resident's nasal cannula when not in use, LPN # 2 stated it should be covered. LPN # 2 further stated, "We ran around about two hours ago checking resident's oxygen and putting the nasal cannulas and nebulizer masks in bags and dating the bags. LPN # 2 did not have a response when informed of the above observations of Resident # 102's nasal cannula not being stored in a bag.

On 06/20/17 an interview was conducted at 2:15 p.m. with RN (registered nurse) # 3. When asked about the procedure for storing a resident's nasal cannula when not in use, RN # 3 stated, "It should be placed in a bag when not in use." When asked if nurses had gone around a couple hours ago checking resident's oxygen and putting the nasal cannulas and nebulizer masks in bags and dating the bags, RN # 3 stated, "Yes." When informed of the observations at 7:45 a.m. and 9:15 a.m. on 06/20/17 of Resident # 102's nasal cannula not covered RN # 3 stated she wasn't aware of it.

On 06/20/17 at 4:30 p.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. When asked about the procedure for storing a resident's nasal cannula when not in use, ASM # 2 stated, "The nasal cannula should be stored in a plastic bag."

On 06/20/17 at approximately 5:00 p.m. AS # 1, 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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(1) There are many different forms of heart disease. The most common cause of heart disease is narrowing or blockage of the coronary arteries, the blood vessels that supply blood to the heart itself. This is called coronary artery disease and happens slowly over time. It's the major reason people have heart attacks. Other kinds of heart problems may happen to the valves in the heart, or the heart may not pump well and cause heart failure. Some people are born with heart disease. This information was obtained from the website: https://medlineplus.gov/heartdiseases.html.

(2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(3) Sleep apnea is a common disorder that causes your breathing to stop or get very shallow. Breathing pauses can last from a few seconds to minutes. They may occur 30 times or more an hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html.

(4) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html

(5) Tubing used to deliver oxygen at levels from 1 to 6 L/min. The nasal prongs of the cannula extend approx. 1 cm into each naris and are

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connected to a common tube, which is then connected to the oxygen source. It is used to treat conditions in which a slightly enriched oxygen content is needed, such as emphysema. The exact percentage of oxygen delivered to the patient varies with respiratory rate and other factors. This information was obtained from the website: http://medical-dictionary.thefreedictionary.com/nasal+cannula.

2b. The facility staff failed to administer Resident # 102's oxygen according to the physician's orders.

An observation conducted on 06/20/17 at 7:45 a.m. revealed Resident # 102 was sitting up in her bed and had finished eating breakfast. Further review of the resident's room revealed the nasal cannula attached to the oxygen tubing, was wrapped around the upper bed rail uncovered. Resident # 102 was not receiving oxygen.

An observation conducted on 06/20/17 at 9:15 a.m. revealed Resident # 102 was sitting up in her bed. Further review of the resident's room revealed the nasal cannula attached to the oxygen tubing, was wrapped around the upper bed rail uncovered. Resident # 102 was not receiving oxygen.

An observation conducted on 06/20/17 at 10:50 a.m. revealed Resident # 102 was sitting up in her wheelchair in the therapy department. Resident # 102 was engaged with exercises with a therapist. Further observation of Resident # 102 revealed a portable oxygen tank on the back of Resident # 102's wheelchair. Resident # 102 was not observed receiving oxygen.

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An observation conducted on 06/20/17 at 12:45 p.m. revealed Resident # 102 was sitting up in her wheelchair in in her room eating lunch. Further observation of Resident # 102 revealed a portable oxygen tank on the back of Resident # 102's wheelchair. Resident # 102 was not observed receiving oxygen.

The physician's order dated 06/13/2017 for Resident # 102 documented, "2L (two liters per minute) O2 (oxygen) via (by) NC (nasal cannula) continuous."

On 06/20/17 an interview was conducted at 2:15 p.m. with RN (registered nurse) # 3. When asked if she was Resident # 102's nurse, RN # 3 stated, "Yes." When asked if Resident # 102 was ordered to receive oxygen, RN # 3 reviewed the physician's order and stated, "She should have oxygen continuously." When informed of the observations at 7:45 a.m., 9:15 a.m., 10:50 a.m. and at 12:45 p.m. on 06/20/17 of Resident #102 not receiving oxygen, RN # 3 stated, "I put it on her about a half an hour ago." When asked to describe the procedure for ensuring residents receive oxygen as prescribed by the physician, RN #3 stated, "I usually check it several times a shift." When asked why Resident # 102 had not received oxygen at 7:45 a.m., 9:15 a.m., 10:50 a.m. and at 12:45 p.m. on 06/20/17, RN #3 stated, "I didn't notice she didn't have it on."

On 06/20/17 at 4:30 p.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. When asked to describe the procedure for ensuring residents receive oxygen continuously as prescribed by the physician, ASM # 2 stated,

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{F 328}	Continued From page 26 "Nursing should check it continually." On 06/20/17 at approximately 5:00 p.m. AS # 1, administrator, and ASM # 2, the director of nursing were made aware of the findings. No further information was provided prior to exit.	{F 328}		
F 507 SS=D	483.50(a)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS (a) Laboratory Services (2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to file laboratory results in the clinical record for one of 14 residents in the survey sample, Resident # 109. The facility staff failed to ensure a physician ordered laboratory test results for BMP [basic metabolic panel (1)], CBC [complete blood count (2)] and HgbA1c [hemoglobin (3)] were filed in Resident # 109's clinical record. The findings include: Resident # 109 was admitted to the facility on 06/09/17 with diagnoses that included but were not limited to: chronic kidney disease (4), heart failure, diabetes mellitus (5), depressive disorder	F 507	F507 1. Resident #109 lab results from June 15, 2017 are in the clinical record. 2. The Director of Nursing/designee will review current residents labs ordered to ensure they are filed in the residents' clinical records. 3. The Director of Nursing/designee will educate nursing staff and the Medical Records coordinator on timely filing lab results in the clinical record. The Director of Nursing/designee will randomly audit lab reports in clinical records three times a week times four weeks and then monthly times two months. 4. The Director of Nursing/designee will report the audit results monthly to the Quality Assurance Performance Improvement committee for continued compliance and/or revision.	7-21-17

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and cerebral vascular disease (6).

Resident # 109's most recent MDS (minimum data set); an admission assessment was not due at the time of survey. Review of the clinical record for Resident # 109 revealed a nursing admission assessment dated 06/09/17. Further review of the nursing admission assessment documented Resident # 109 was cognitively intact of cognition for making daily decisions.

Review of the POS (physician order sheet) dated June 2017 documented, "Laboratory. BMP and HgbA1c, CBC to be drawn on 6/15/17."

Review of Resident # 109's clinical record failed to evidence the results of the BMP, HgbA1c and CBC laboratory tests for 06/15/2017.

An interview was conducted on 06/20/17 at 10:45 a.m. with LPN # 4 (licensed practical nurse) # 4 and LPN # 6 regarding the BMP, HgbA1c and CBC laboratory test results for Resident # 109. LPN # 4 stated, "We print the results from (Name of Laboratory) or they fax them, usually at the end of the day." LPN # 6 stated, "It should be in the resident's clinical record." LPN # 4 provided this surveyor with a copy of the BMP, HgbA1c and CBC laboratory test results for Resident # 109 on 06/20/17 at approximately 11:00 a.m. LPN # 4 stated she had printed the laboratory results from the (Name of Laboratory) website.

The BMP, HgbA1c and CBC laboratory test results for Resident # 109 from (Name of Laboratory) documented, "RPTD (Report Date): 06/15/2017."

On 06/20/17 at approximately 5:00 p.m. AS # 1,

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administrator, and ASM # 2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) The basic metabolic panel is a group of blood tests that provides information about your body's metabolism. This information was obtained from the website:
https://medlineplus.gov/ency/article/003462.htm.

(2) A complete blood count (CBC) test measures the following: the number of red blood cells (RBC count), the number of white blood cells (WBC count), the total amount of hemoglobin in the blood and the fraction of the blood composed of red blood cells (hematocrit). The CBC test also provides information about the following measurements: average red blood cell size (MCV), hemoglobin amount per red blood cell (MCH) and the amount of hemoglobin relative to the size of the cell (hemoglobin concentration) per red blood cell (MCHC). This information was obtained from the website:
https://medlineplus.gov/ency/article/003642.htm.

(3) HGA1C -The A1C test is a blood test that provides information about a person's average levels of blood glucose, also called blood sugar, over the past 3 months. The A1C test is sometimes called the hemoglobin A1c, HbA1c, or glycohemoglobin test. The A1C test is the primary test used for diabetes management and diabetes research. Taken from:
http://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta.

(4) Kidneys are damaged and can't filter blood as

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they should. This information was obtained from the website:
https://medlineplus.gov/chronickidneydisease.htm l.

(5) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(6) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website:
https://medlineplus.gov/ency/article/000726.htm .

{F 514} SS=D — 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE — {F 514}

(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-

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(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for three of 14 residents in the survey sample, Resident's #113, #107, and #112.

1. The facility staff failed to document the non-pharmacological interventions that were provided prior to the administration of PRN (as needed) pain medication for Resident #113.

2. The facility staff failed to document the non-pharmacological interventions that were provided prior to the administration of PRN (as needed) pain medication for Resident #107.

3. The facility staff failed to document non-pharmacological interventions provided to Resident #112 prior to as needed pain medication

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1. Resident #113 pain assessment conducted and care plan updated. Resident #107 pain assessment conducted and care plan updated. Resident #112 pain assessment conducted and care plan updated.

2. The Director of Nursing/designee will review current residents' records to ensure records are complete and accurate for non-pharmacological interventions prior to administration of prn pain medications.

3. The Director of Nursing/designee will educate nursing staff of completeness, accuracy, and documenting non-pharmacological interventions according to residents comprehensive care plan. The Director of Nursing/ designee will randomly audit resident clinical records for completeness and accuracy three times a week times four weeks and then monthly times two months.

4. The Director of Nursing/designee will report the audit results monthly to the Quality Assurance Performance Improvement committee for continued compliance and/ or revision.

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administration.

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The findings include:

1. Resident #113 was admitted to the facility on 3/10/17 with a recent readmission on 5/13/17 with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease - general term used for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), high blood pressure, depression, diabetes, obesity, blindness in right eye, heart disease, arthritis of knees, and muscle weakness.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/13/17, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating she was capable of making cognitive daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she was coded as requiring supervision after set up assistance was provided. In Section O - Special Treatments, Procedures and Problems, the resident was coded as receiving oxygen while a resident at the facility.

The physician order dated, 5/15/17, documented, "Hydrocodone - Acetaminophen Tablet* 10 -325 MG (milligrams); Give 1 tablet by mouth every 6 hours as needed for pain." *Hydrocodone - Acetaminophen is also known as Vicodin and is used to treat moderate to severe pain. (2).

The June 2017 MAR (medication administration record) documented: "Hydrocodone -

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Acetaminophen Tablet 10 -325 MG; Give 1 tablet by mouth every 6 hours as needed for pain." The MAR documented that it was administered on 6/18/17 at 1342 (1:42 p.m.) by LPN (licensed practical nurse) #2.

The eMAR (electronic medication administration records) dated, 6/18/17 at 13:42, documented: "Resident c/o (complained of) bilateral leg pain. 6/10 (six out of ten) with 10 being the worst."

Review of the nurse's notes did not reveal any nurse's note on 6/18/17.

The comprehensive care plan dated, 3/21/17, documented in part, "Focus: Needs Pain Management and monitoring related to Osteoarthritis, osteoporosis, DM (diabetes mellitus)." The "Interventions" documented, "Administer pain medication as ordered. Attempt repositioning for comfort. Dim lighting/quiet environment. Utilize pain monitoring tool to evaluate effectiveness of interventions."

An interview was conducted with Resident #113 on 6/20/17 at 9:15 a.m. When asked what the nurses do if she complains of pain, Resident #113 stated, "They ask you to describe the pain from one to ten and then ask where it is." When asked if they offer to reposition her, offer her a drink or snack, Resident #113 stated, "No."

An interview was conducted with LPN #2 on 6/20/17 at 1:28 p.m. LPN #2 was asked to describe what actions she would take if a resident complains of pain, LPN #2 stated, "First it depends on the pain. If it's a headache I would try a warm compress, trying less invasive things prior to medication? The resident has the right to

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accept or refuse the less invasive treatment." When asked about 6/18/17, LPN #2 stated, "It was towards the end of the shift. She told me she needed her pain medication because both of her legs were hurting. I suggested she go back to bed and she refused. I also tried to scoot her back in her chair but due to her size, there wasn't room to get her to scoot back." When asked where she documented that she offered to put the resident back in her bed to rest her legs, LPN #2 stated, "I will not lie, I didn't document it."

An interview was conducted with administrative staff member (ASM [administrative staff member]) #2, the director of nursing, on 6/20/17 at 4:35 p.m., regarding the process staff follows when residents' complain of pain. ASM #2 stated, "You find out where the pain is and asked them to rate it. You off other interventions for pain prior to the pain medications, music, back or feet rubs." When asked where this is documented, ASM #2 stated, "In a nurse's note." A policy for non-pharmacological interventions offered prior to the administration of PRN pain medications and the documentation of those interventions was requested from ASM #2.

The facility document, "Pain Assessment" documented in part, "3. A Pain Flow Record will be maintained with the resident's Medication Administration Record. This is to be completed when the resident has identified they have pain. Record the following: ...f. Interventions - non-med (medication)/medication."

The following quotation is found in Lippincott's Fundamentals of Nursing 5th edition (2007, page 237): "The client record serves as a legal document of the client's health status and care

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received .....Because nurses and other healthcare team members cannot remember specific assessments or interventions involving a client years after the fact, accurate and complete documentation at the time of care is essential. The care may have been excellent, but the documentation must prove it."

The administrator and ASM #2 were made aware of the above findings on 6/20/17 at 5:03 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman, page 124.
(2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/?report=details.

2. The facility staff failed to document the non-pharmacological interventions that were provided prior to the administration of PRN (as needed) pain medication for Resident #107.

Resident #107 was admitted to the facility on 11/17/16 with a recent readmission on 5/2/17 with diagnoses that included but were not limited to: diabetes, chronic pain, muscle weakness, anxiety, bipolar disorder (a mental disorder characterized by episodes of mania and depression (1)), and high blood pressure.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 5/8/17, coded the

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resident as scoring a 15 on the BIMS (brief interview for mental status) score indicating that the resident was capable of making daily cognitive decisions. The resident was coded as requiring supervision or as being independent with set up assistance or one person assistance for all of her activities of daily living.

The physician order dated, 5/2/17, documented, "Norco *(Hydrocodone - Acetaminophen) 10 - 325 MG (milligrams); Give 1 tablet by mouth every 8 hours as needed for pain." *Norco - Hydrocodone - Acetaminophen is an opioid analgesic used to treat moderate to severe pain. (2).

The June 2017 MAR (medication administration record) documented, "Norco Tablet 10 - 325 MG; Give 1 tablet by mouth every 8 hours as needed for pain." The MAR documented the resident received the Norco on the following dates and times:
6/9/17 at 5:25 a.m. - administered by LPN (licensed practical nurse) #5.
6/11/17 at 8:12 p.m.
6/12/17 at 11:53 a.m.
6/12/17 at 7:53 p.m. - administered by LPN #4.
6/14/17 at 8:07 p.m.
6/15/17 at 4:57 p.m. - administered by LPN #4.
6/16/17 at 4:41 p.m.
6/17/17 at 4:33 p.m.
6/18/17 at 3:01 a.m. - administered by LPN #4.
6/18/17 at 8:44 p.m. - administered by ASM (administrative staff member) #2.
6/20/17 at 12:24 a.m. - administered by LPN #5.

The nurse's notes dated, 6/9/17 at 5:25 a.m. documented, "Patient states her toes are hurting in the joints. Requests medication for pain

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management."

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The nurse's note dated, 6/11/17 at 8:12 p.m. documented, "Give 1 tablet by mouth every 8 hours for pain."

The nurse's note dated, 6/12/17 at11:53 a.m. documented, "Give 1 tablet by mouth every 8 hours for pain."

The nurse's note dated, 6/12/17 at 7:53 p.m. documented, "Resident requests one Norco 10-325 mg tab (tablet) for pain per MD (medical doctor) PRN (as needed) order; administered same."

The nurse's note dated, 6/14/17 at 8:07 p.m. documented, "Give 1 tablet by mouth every 8 hours as needed for Pain."

The nurse's note dated, 6/15/17 at 4:57 p.m. documented, "Resident requests one 10-325 mg Norco tab for pain per MD PRN order; administered one."

The nurse's note dated, 6/16/17 at 4:41 p.m. documented, "Give 1 tablet by mouth every 8 hours as needed for Pain."

The nurse's note dated, 6/17/17 at 4:33 p.m. documented, "Give 1 tablet by mouth every 8 hours as needed for Pain."

The nurse's note dated, 6/18/17 at 3:01 a.m. documented, "Resident requests one 10-325 mg Norco tab for pain per MD PRN order; administered one."

The nurse's note dated, 6/18/17 at 8:44 p.m.

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FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

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documented, "Requested pin med (medication) for pain 5/10 (five out of ten, ten being the worse pain ever in)."

The nurse's note dated, 6/20/17 at 12:24 a.m. documented, "Patient complains of pain in her toes, feet. Requested medication for pain management."

The comprehensive care plan dated, 7/13/16 documented in part, "Focus: Resident needs Pain management and monitoring related to: DX (diagnosis) DM (diabetes mellitus) with polyneuropathy (abnormal condition of the peripheral nerves in multiple places (3)) and arthritis of hands." The "Interventions" documented in part, "Administer pain medication as ordered by physician. Encourage rest periods and elevating BLE (bilateral lower extremities). Implement the patient's preferred non-pharmacological pain strategies as needed: dim lights, soft music, offer comfort food and/or beverage, provide quiet atmosphere, offer soothing massage."

An interview was conducted with ASM #2, the director of nursing, on 6/20/17 at 11:35 a.m. When asked if the nurse should document non-pharmacological interventions prior to giving a PRN pain medication, ASM #2 stated, "I, as a nurse would document what I've done for the resident." When asked if there was a facility policy regarding this, ASM #2 stated, "I don't know if we have a policy related to that."

An interview was conducted with LPN #5 on 6/20/17 at 3:40 p.m. When asked what she does when a resident complains of pain, LPN #5 stated, "A couple of people here are care planned

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just to give them their medications instead of repositioning or putting their legs ups. I have to ask where the pain is, what makes it worse or better and I have them rate their pain. First thing I do after that is reposition them." The MAR and nurse's notes were reviewed with LPN #5. LPN #5 stated, "I didn't know to document those things, whatever you do for a resident we should take credit for it." When asked if she could recall the mornings that she gave Resident #107 her pain medication, LPN #5 stated, "She was up walking around stating 'my feet hurt'. She had already propped them up." On 6/14/17 LPN #5 stated she could not remember what she did for her.

An interview was conducted with LPN #4 on 6/20/17 at 3:46 p.m. When asked what she does when a resident complains of pain, LPN #4 stated, "First I investigate the degree of pain, the location and circumstances. Then I take appropriate action." When asked what appropriate action is, LPN #4 stated, "I contact the doctor and offer the doctor suggestions as to what's done." When asked if there is anything else she would do for the resident, LPN #4 stated, "I would attempt non-pharmacological interventions like elevating their feet, offering massage, or trying to distract them." When asked where that is documented, LPN #4 stated, "In the nursing notes." When asked if she had any non-pharmacological interventions prior to administering Resident #107 her pain medication, LPN #4 stated, "I did them but the nursing rules are if it's not documented it's not done." When asked if Resident #107 was receptive to non-pharmacological interventions, LPN #4 stated, "Yes, she is."

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An interview was conducted with ASM #2, the director of nursing, on 6/20/17 at 4:35 p.m., regarding the process staff follow when a resident complains of pain, ASM #2 stated, "First you find the location and intensity of pain, done on the pain scale. Then you attempt other interventions prior to administering the pain medications such as music, back and feet rubs." When asked where that information is documented, ASM #2 stated, "The nurse's note." The MAR and nurse's notes for 6/18/17 at 8:44 p.m. were reviewed with ASM #2. When asked where the other interventions were documented for Resident #107, ASM #2 stated, "There not there. I did not document the non-pharmacological interventions." When asked what she attempted, ASM #2 stated, "I made sure she had music to listen to, I tried to dim her lights but she didn't want that." When asked where all of that is documented, ASM #2 stated, "I didn't document it." When asked should that be documented, ASM #2 stated, "Yes Ma'am."

The administrator and ASM #2 were made aware of the above findings on 6/20/17 at 5:03 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman, page 73.
(2) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=aaef2d01-126d-4aab-9b2a-eee31a769150
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and

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Chapman, page 402 and 465

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3. The facility staff failed to document non-pharmacological interventions provided to Resident #112 prior to as needed pain medication administration.

Resident #112 was admitted to the facility on 5/19/17. Resident #112's diagnoses included but were not limited to: liver cancer, chronic pain and high cholesterol. Resident #112's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 6/2/17, coded the resident as cognitively intact.

Review of Resident #112's clinical record revealed a physician's order dated 5/19/17 for Endocet (1) 5/325 mg (milligrams) - two tablets by mouth every six hours as needed for a pain level of seven to ten on a scale from zero to ten. Review of Resident #112's June 2017 MAR (medication administration record) revealed the resident was administered as needed Endocet on the following days (including but not limited to):
6/11/17
6/12/17
6/15/17
6/19/17

Further review of Resident #112's clinical record (including MAR notes and nurses' notes) failed to reveal documentation that nurses provided non-pharmacological interventions prior to administering as needed Endocet to Resident #112 on the above dates.

Resident #112's comprehensive care plan

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initiated on 5/24/17 documented, "(Name of Resident #112) is at risk for pain and needs monitoring ...Implement preferred non-pharmacological pain relief strategies: i.e. Offer soothing massage, Dim lights, play soothing music, Offer comfort foods and or beverages, Check environmental factors, Before administering Prn (as needed) pain medications ..." The care plan failed to document information regarding the documentation of non-pharmacological interventions.

On 6/20/17 at 8:50 a.m. an interview was conducted with Resident #112. Resident #112 was asked if nurses attempt non medication interventions prior to administering pain medication to her. Resident #112 stated, "Yeah. They provide lotions and stuff like that."

On 6/20/17 at 10:36 a.m. an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what she provides to residents prior to administering as needed pain medication. LPN #1 stated, "You can do something else to alleviate pain, maybe activities. Ask if you can do something else to help relieve the pain." LPN #1 was asked if she documents the attempted non-pharmacological interventions. LPN #1 stated, "If you do that you have to document." LPN #1 stated she documents the information in the nurses' progress notes.

On 6/20/17 at 11:35 a.m. an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated she would document attempted non-pharmacological interventions because the documentation shows what she did before medication was administered. ASM #2 was

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{F 514}	Continued From page 42 made aware of the above concern. On 6/20/17 at 2:26 p.m. ASM #1 (the administrator) was made aware of the above concern. The facility policy titled, "Pain Assessment" documented, "3. A Pain Flow Record will be maintained with the resident's Medication Administration Record. This is to be completed when the resident has identified they (sic) have pain. Record the following ...f. Interventions-non-med / medication ..." No further information was presented prior to exit. (1) Endocet is used to treat pain. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=944d3e60-7eee-11de-a413-0002a5d5c51b	{F 514}		