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GRACE HEALTHCARE OF ABINGDON

FAX COVER SHEET

TO: Rodney Miles

FROM: Angela Chitwood

COMPANY: O

DATE: 3/15

FAX NUMBER: 804-527-4502

TOTAL NO. OF PAGES INCLUDING COVER: 22

PHONE NUMBER:

CC:

RE:

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NOTES/COMMENTS:

Grace
HEALTHCARE of ABINGDON
SERVING YOU FROM OUR HEART

March 13, 2017

Mr. Rodney Miller, LTC Supervisor

Office of Licensure and Certification

Division of Long Term Care Services

9960 Maylard Drive, Suite 401

Henrico, Virginia 23233-1485

Re: Grace Healthcare of Abingdon (Provider Number 1992796007)

Survey ending February 23, 2017

Dear Mr. Miller

Enclosed for your review, please find our updated plan of correction for the survey ending February 23, 2017. We submit this plan of correction as Grace Healthcare of Abingdon's allegation of compliance. Please contact me directly if you have any questions that require additional information.

Sincerely,

Angela Chitwood-Owens

Angela Chitwood-Owens

Administrator

600 Walden Road
Abingdon, VA 24210
p 276.628.2111
f 276 628.8848
www.gracehc.com

PRINTED: 03/03/2017
FORM APPROVED
CMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495338	A. BUILDING _____ B. WING _____	R 02/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF ABINGDON	600 WALDEN ROAD ABINGDON, VA 24210

(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	(F 000)		3/13/17

An unannounced Medicare/Medicaid second revisit to the 1/10/17 through1/11/17 first revisit and the 11/10/16 standard survey was conducted 02/22/17 through 02/23/17. 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 120 certified bed facility was 100 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents #201 through #212).

(F 309) SS=D — 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING — (F 309)

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to follow physician orders for 2 of 12 Residents, Residents #204 and #208.

1. For Resident #204, the facility staff administered the physician ordered medication nuedexta once a day when the order was for twice a day.

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F 309

1. Resident # 204 was assessed by the Licensed Nurse on 2/24/17. No adverse outcomes were noted. The order for Nuedexta was corrected to be given twice daily on 2/22/17 by the Unit Manager on the MAR. The Responsible Party and Physican were notified of the error by the Licensed Nurse.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angie Whitwood-Owens	Administrator	3/13/2017

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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				3/13/17

(F 309) Continued From page 1

(F 309)

2. For Resident #208, the facility staff failed to administer the physician ordered medication Ativan 0.5mg every six hours via (gastrostomy) peg tube.

The findings included

1. For Resident #204, the facility staff administered the physician ordered medication nuedexta once a day when the order was for twice a day.

Per the national institute of health nuedexta is a prescription medication indicated for the treatment of (PBA) pseudobulbar affect. PBA occurs secondary to a variety of otherwise unrelated neurologic conditions, and is characterized by involuntary, sudden, and frequent episodes of laughing and/or crying

The record review revealed that Resident #204 had been admitted to the facility 11/02/16 Diagnoses included, but were not limited to, PBA, metabolic encephalopathy, dysphagia, vascular dementia, stage IV chronic kidney disease, and essential hypertension.

Section C (cognitive patterns) of the Residents quarterly review MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/01/17 included a BIMS (brief interview for mental status) summary score of 8 out of a possible 15 points.

The clinical record included a physician telephone order dated and signed by the physician on 01/24/17. This telephone order read "(1) Start Nudexta (sic) 20/10 PO (by mouth) Qday

Resident # 208 was assessed by the Licensed Nurse on 2/24/17. No adverse outcomes were noted. The licensed nurse was in-serviced on medication administration and documentation on 2/23/17 by the Registered Nurse. The Responsible Party and Physican were notified of the omissions of the med by the Licensed Nurse.

2. All orders for Neudexta and Ativan wer audited by the Unit Managers on 2/27/17 to ensure compliance and documentation. No issues were identified.

3. Licensed Nurses on were in-serviced on Medication Administration by the Assistant Director of Nursing on 2/22/17 – 3/7/17. Any Licensed Nurses not in-serviced by 3/7/17 will not be allowed to work unit the inservice education is provided.

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(F 309)	Continued From page 2 (everyday) X 7 days then increase to Nudexta (sic) 20/10 BID (twice a day) for PBA..." A review of the Residents eMAR's (electronic medication administration records) for January and February 2017 revealed that this medication had been administered one time a day beginning January 25 at 8.00 a.m. However the facility staff failed to increase this medication to BID as ordered by the physician after 7 days (February 1) and continued to administer the medication one time a day throughout the month of February. On 02/22/17 at approximately 3.20 p.m. administrative staff #2 was notified that the facility staff had not administered the medication as ordered by the physician. On 02/22/17 at approximately 3.25 p.m. administrative staff #2 acknowledged that the medication had not been administered as ordered and stated the order had been corrected. On 02/22/17 at approximately 3:50 p.m. the unit manager verbalized to the surveyor that it appeared that a new nurse had entered this order into the electronic system and the nurse that had checked behind her didn't change the times to BID. On 02/23/17 at approximately 10:40 a.m. the survey team meet with the administrative staff of the facility. During this meeting the administrative staff was notified that Resident #204 had not received the physician ordered medication nuedexta as ordered by the physician. No further information regarding this issue was provided to the survey team prior to the exit	(F 309)	The Unit Managers were in-serviced on checking new physican orders daily to ensure the transcription was completed correctly by the Director of Nursing on 2/23/17. 4. An audit of 5 medication administration records will be conducted by the Unit Managers or designee weekly for 4 weeks for residents on Nuedexta and Ativan. Then 3 medication administration records weekly for 4 weeks for residents on Nuedexta and Ativan. Then 1 medication administration record weekly for 4 weeks for residents on Nuedexta and Ativan and/or 100% compliance by the Director of Nursing. The results of the audits will be presented by the Director of Nursing to the Quality Assurance/Performance Improvement Committee for 3 months and/or until substantial compliance is achieved.	3/13/17

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				3/13/17

(F 309) Continued From page 3

(F 309)

conference.
2. The facility staff failed to administer the physician ordered medication Ativan 0.5mg every six hours via (gastrostomy) peg tube for Resident #208.

Resident #208 was admitted to the facility 12/12/16. Diagnoses included, but were not limited to anemia, hypertension, anxiety diabetes, aphasia, and respiratory failure

The most recent MDS (minimum data set) assessment completed on this resident was a quarterly with an ARD (assessment reference date) of 10/11/16, assessed the resident to rarely understand and to rarely be understood. In Section C, her cognitive score was assessed to be a 1/1 to indicate both short and long term memory problems with severely impaired decision making.

Review of Resident #208's clinical record revealed a physician's order dated 12/26/15 for Ativan 0.5mg every six hours via peg tube.

A review of the resident's current MAR (medication administration record) indicated the facility staff had not administered the Ativan every six hours on 2/1/17 and 2/18/17. The medication was documented as not administered on 2/1/17 at 12:00p.m., and at 6:00a.m. on 2/18/17. There was no documentation that indicated the reason the medication was held. There was no documentation to indicate an assessment was done to warrant the holding of the Ativan. The surveyor did not locate any documentation that the physician had been notified the medication had been held

The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Unit Managers, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.

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(F 309)	Continued From page 4 The medication nurse who had held the medication was not available for interview. The ADON assistant director of nurses was asked if he would have expected the nurse to have administered the medication. He stated it would depend on the vital signs. No complete set of vital signs were provided to the surveyor after they were requested. However, a normal pulse for the days in question were provided; 88 for 2/1/17 and 82 for 2/18/17. The surveyor informed the administrative staff of the above finding on 2/23/17 at 10:40a.m. The regional nurse consultant was asked if she would have expected the nurse to have administered the medication. She stated, "I would have expected an assessment and the physician contacted if she did not." No further information was made available prior to the exit conference on 2/23/17.	(F 309)		3/13/17
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314	F 314 1. Resident # 202 was assessed by the Assistant Director of Nursing on 2/22/17. No negative outcomes were identified. The responsible party and physician were notified of the omissions.	

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F 314	Continued From page 5	F 314		3/13/17

Based on staff interview and clinical record review, the facility staff failed to provide treatments for preventive skin care for 2 of 12 Residents. Residents #202 and #210.

1. For Resident #202, the facility staff failed to follow physician orders in regards to the following treatments-bed bolsters, heavy zinc to sacrum, heel protectors, and betadine to bilateral feet

2. For Resident #210, the facility staff failed to provide treatment for the prevention of pressure areas

The findings included

1. For Resident #202, the facility staff failed to follow physician orders in regards to the following treatments-bed bolsters, heavy zinc to sacrum, heel protectors, and betadine to bilateral feet.

The record review revealed that Resident #202 had been admitted to the facility 02/19/14. Diagnoses included, but were not limited to, dementia, constipation, hypothyroidism, chronic pain, and anxiety disorder.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/08/16 was coded (1/1/3) to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. Section G (functional status) was coded (3/3) to indicate the Resident required extensive assistance of two plus people for bed mobility. Section M (skin conditions) was coded to indicate the Resident did not have any pressure ulcers but was at risk

Resident #210 was assessed by the Assistant Director of Nursing on 2/22/17. No negative outcomes were identified. The responsible party and physician were notified of the omissions.

2. All residents in house had a head to toe skin assessment completed on 2/22/17 by the Assistant Director of Nursing, the Unit Managers, and the Minimum Data Set Nurses. All residents requiring skin wound care were correctly indentified on the TAR.

3. Licensed Nurses on were in-serviced on following treatment orders, and treatment documentation by the Assistant Director of Nursing on 2/22/17 – 3/7/17. Any Licensed Nurses not in-serviced by 3/7/17 will not be allowed to work unit the inservice education is provided.

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F 314	Continued From page 6 for developing pressure ulcers. The Residents CCP (comprehensive care plan) included the problem areas-requires assistance with ADL's (activities of daily living), at risk for nutritional deficit, at risk for skin breakdown with wounds to both feet related to PVD (peripheral vascular disease). Approaches included, but were not limited to, apply foam dressing to bilateral feet bony prominence's, provide treatments to bilateral foot ulcer and right lateral shin per physician's orders, and observe for and report signs and symptoms of skin breakdown. The Residents braden score dated 02/15/17 was documented at a 10. Per the preprinted code on the form this put the Resident at a high risk for skin breakdown. The current POS (physician order sheet) included the following orders. Bed bolsters both bilateral bed sides, heavy zinc twice daily to sacrum, heel protectors to bilateral feet as tolerated (this order was discontinued on 02/22/17), and paint foot wounds with betadine and apply foam dressing daily. The Resident was on comfort care. A review of the Residents eTAR's (electronic treatment administration records) for February 2017 revealed that RN (registered nurse) #2 had documented "N" for the Residents treatments on the following dates. For bed bolsters, heavy zinc to sacrum twice daily, and heel protectors-02/06, 02/07, 02/11, 02/12, 02/13, 02 16, 02/18, and 02/19 For paint foot wounds with betadine and apply foam dressing daily-02/11, 02/12, 02/13, 02/16,	F 314	The Unit Managers were inserviced by the DON on checking MAR's and TAR's for completeness on 2/23/17. 4. An audit of 5 treatment administration records will be conducted by the Unit Managers or designee weekly for 4 weeks. Then 3 treatment administration records weekly for 4 weeks. Then 1 treatment administration record weekly for 4 weeks and/or 100% compliance by the Director of Nursing. The results of the audits will be presented by the Director of Nursing to the Quality Assurance/Performance Improvement Committee for 3 months and/or until substantial compliance is achieved. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Unit Managers, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.	3/13/17

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F 314	Continued From page 7 02/18, 02/19, and 02/21. For the days marked with an "N" on the eTAR's RN #2 had documented the following-Not administered by assigned nursing staff or not performed by scheduled staff. On 02/22/17 at approximately 4:20 p.m. the surveyor interviewed RN #2 regarding treatments for this Resident. RN #2 verbalized to the surveyor that she had been hired in January 2017 and she did not work weekends. She then stated that at times when she would log onto the computer system to check orders etc some orders would show up in red indicating the previous nursing staff had not documented they had completed the treatment(s). RN #2 stated that in order to proceed and access what she needed to complete her treatments she had to document something. On 02/23/17 at approximately 8:30 a.m. the unit manager was asked about the physician ordered treatments for Resident #202. The unit manager stated if she worked the hall she did the treatments especially for this Resident. On 02/23/17 at approximately 8:35 a.m. the surveyor interviewed LPN (licensed practical nurse) #2. LPN #2 identified her initials on the eMAR (electronic medication record) for 02/18/17. LPN #2 was then asked if she would have been responsible for completing the treatments on this date to which she replied she would. When asked why she had not documented that she had completed the treatments LPN #2 stated that sometimes we just don't have time to do treatments.	F 314		3/13/17

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F 314	Continued From page 8	F 314		3/13/17

On 02/23/17 the RN #2 (treatment nurse) shared with the surveyor a copy of measurements of the Residents wounds from 01/25-02/22/17 these measurements were unchanged.

During a meeting with the survey team on 02/23/17 at approximately 10:40 a.m. the administrative team of the facility was notified of the above issues

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. For Resident #210, the facility staff failed to provide treatment for the prevention of pressure areas.

Resident #210 was admitted to the facility on 09/30/16. Diagnoses included but not limited to hemiplegia, atrial fibrillation, diabetes mellitus, hypertension, hyperlipidemia, dementia, anxiety, depression, and insomnia.

The most recent MDS (minimum data set) with and ARD of 12/30/16 coded the Resident as 0 out of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #210's CCP (comprehensive care plan) was reviewed at this time. It contained a care plan which read in part "Problem/Need ...is at risk for skin breakdown R/T (related to) decreased mobility and incontinence. Goal & Target Date: Will have no skin breakdown R/T pressure/incontinence x 92 days. Approaches: Provide treatment as ordered See current TAR (treatment administration record)".

Resident #210's clinical record was reviewed on 02/22/17. It contained a signed POS (physician's

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F 314	Continued From page 9	F 314		3/13/17

order summary), which read in part "Apply heavy zinc oxide to gluteal area twice a day and prn (as needed)". Resident #210's TAR's were reviewed and contained an entry which read in part "Apply heavy zinc oxide to gluteal area twice a day and prn". This entry was marked with "N" on the following days and times: 02/04, 02/05, 02/10 02/12, 02/16, 02/19 at 7am, and 02/07, 02/12, 02/13, 02/14 at 7pm. Notes in the comments section of the TAR for each of these entries read in part "Apply heavy zinc oxide to gluteal area t...scheduled for 02/ /2017 7:00 AM/PM, not administered by assigned nsg (nursing) staff".

Surveyor spoke with RN #2 (registered nurse), who is the treatment nurse, on 02/22/17 at approximately 1620 regarding the "N" on the TAR's. RN #2 stated that she has been doing treatments since Jan 2017 and that she only works weekdays. She stated that when she went to the computer to sign for her completed treatments on Resident #210, the computer would not let her complete her treatments until she put something in the blank areas that had not been signed for. Stated she was worried about how it would show up, but had to put something there in order for the computer to allow her to proceed. Stated that she made a note saying treatment not administered by assigned nurse

On 02/23/17 at approximately 0835 surveyor #2 interviewed LPN (licensed practical nurse) #2. LPN #2 identified her initials on the eMAR (electronic medication record) for 02/18/17. LPN #2 was then asked if she would have been responsible for completing the treatments on this date to which she replied she would. When asked why she had not documented that she had completed the treatments LPN #2 stated that

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F 314	Continued From page 10 sometimes we just don't have time to do the treatments. Surveyor spoke with RN #2 again on 02/23/17 at approximately 0905 regarding Resident #210's treatment order. RN #2 stated that Resident #210 did not have any pressure areas, and the zinc was ordered as a preventative measure The concern of the treatments not being completed was discussed during a meeting with the administrative team on 02/23/17 at approximately 1040. No further information was provided prior to exit.	F 314		3/13/17
(F 328) SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to follow physician orders in regards to a PICC line for 1 of 12 Residents. Resident #202	(F 328)	F 328 1. Resident # 202 was assessed by the Assistant Director of Nursing on 2/22/17. No adverse outcomes noted. Responsible party was made aware of the omissions on the TAR. Physician was notified of the omitted observations by the licensed nurse. 2. All residents in house had a head to toe skin assessment completed on 2/22/17 by the Assistant Director of Nursing, the Unit Managers, and the Minimum Data Set Nurses. All residents requiring PICC care were correctly identified on the TAR.	

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(F 328)	Continued From page 11	(F 328)		3/13/17

The findings included

The facility nursing staff failed to follow the physicians order in regards to monitoring Resident #202's right upper extremity for signs and symptoms of infection due to the placement of a PICC line.

A PICC line is a peripherally inserted central catheter. It is used for treatments such as intravenous fluids (IV), drugs, or blood transfusions.

The record review revealed that Resident #202 had been admitted to the facility 02/19/14. Diagnoses included, but were not limited to, osteomyelitis, dementia, constipation, hypothyroidism, chronic pain, and anxiety disorder.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/08/16 was coded (1/1/3) to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making.

The Residents CCP (comprehensive care plan) had been updated on 01/31/17 to include the problem of osteomyelitis. Approaches included, but were not limited to: assess/monitor and report signs and symptoms of infection i.e., redness, fever, swelling, drainage, pain.

The current POS (physician order sheet) included the physician order-"monitor right upper extremity for signs and symptoms of infection while picc line in place."

3. Licensed Nurses on were in-serviced on following treatment orders, and treatment documentation by the Assistant Director of Nursing on 2/22/17 – 3/7/17. Any Licensed Nurses not in-serviced by 3/7/17 will not be allowed to work unit the inservice education is provided.

   The Unit Managers were in-serviced by the DON on checking MAR's and TAR's daily for completeness on 2/23/17.

4. An audit of up to 5 treatment administration records for resident with PICC lines will be conducted by the Unit Managers or designee weekly for 4 weeks. Then up to 3 treatment administration records for residents with PICC lines weekly for 4 weeks. Then 1 treatment administration record weekly for 4 weeks for residents with PICC lines and/or 100% compliance by the Director of Nursing. The results of the

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(F 328)	Continued From page 12	(F 328)		3/13/17

A review of the Residents eTAR's (electronic treatment administration records) for February 2017 revealed that RN (registered nurse) #2 had documented "N" beside the order to monitor the P.C.C. line on the following dates 02/06, 02/07, 02/11, 02/12, 02/13, 02/16, 02/18 and 02/19.

For the days marked with an "N" on the eTAR's RN #2 had documented the following "not administered by assigned nursing staff..."

On 02/22/17 at approximately 4:20 p.m. the surveyor interviewed RN #2 regarding treatments for this Resident. RN #2 verbalized to the surveyor that she had been hired in January 2017 and she did not work weekends. She then stated that at times when she would log onto the computer system to check orders etc...Some orders would show up in red indicating the previous nursing staff had not documented they had completed the treatment(s). RN #2 stated that in order to proceed and access what she needed to complete her treatments she had to document something.

On 02/23/17 at approximately 8:30 a.m. the unit manager was asked about the above treatments. The unit manager stated if she worked the hall she did the treatments especially for this Resident.

On 02/23/17 at approximately 8:35 a.m. the surveyor interviewed LPN (licensed practical nurse) #2. LPN #2 identified her initials on the eMAR (electronic medication record) for 02/18/17. LPN #2 was then asked if she would have been responsible for completing the treatments on this date to which she replied she

audits will be presented by the Director of Nursing to the Quality Assurance/Performance Improvement Committee for 3 months and/or until substantial compliance is achieved. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Unit Managers, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.

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(F 328)	Continued From page 13 would. When asked why she had not documented that she had completed the treatments LPN #2 stated that sometimes we just don't have time to do treatments. During a meeting with the survey team on 02/23/17 at approximately 10:40 a.m. the administrative team of the facility was notified of the above. No further information regarding this issue was provided to the survey team prior to the exit conference.	(F 328)		3/13/17
(F 431) SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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.	(F 431)	F 431 1. The narcotic box in Med Room refrigerator on Side 1 was secured to the refrigerator on 2/23/17 by the Maintenance Director. 2. This alleged deficient practice has the potential to affect residents on side 1 and was corrected on 2/23/17.	

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(F 431)	Continued From page 14 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 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, and clinical record review, the facility staff failed to ensure the narcotic box on 1 of 2 units (unit 1) was permanently affixed. The findings included The facility staff failed to ensure the narcotic box in the refrigerator on unit 1 was permanently affixed. The medication room on unit 1 was checked on 2/23/17 at 7:55a.m. with LPN (licensed practical nurse) #2. The refrigerator contained a black box that was easily removed from the refrigerator by the nurse. LPN #4 identified this box as a box to store the narcotic syringes. The surveyor asked the LPN to remove this box from the refrigerator. The nurse unlocked the box and the surveyor was able to observe the contents. The box contained 30 Ativan 2mg/ml sublingual syringes. The unit manager was informed of the lock box not being permanently affixed on 2/23/17 at	(F 431)	3/13/17 3. Licensed nurses were in-serviced to write a TELS work order if the narcotic box needs to be secure on 2/22/17 – 3/7/17 by the Director of Nursing or designee. Any Licensed Nurses not in-serviced by 3/7/17 will not be allowed to work unit the inservice education is provided. 4. An audit of the two refrigerated narcotic lock boxes will be conducted by the Unit Managers or designee weekly for 4 weeks. Then 3 audits of the two refrigerated narcotic lock box weekly for 4 weeks. Then 1 audit of the two refrigerated narcotic lock box weekly for 4 weeks and/or 100% compliance by the Director of Nursing. The results of the audits will be presented by the Director of Nursing to the Quality Assurance/Performance Improvement Committee for 3 months and/or until substantial compliance is achieved. The Quality Assurance/Performance Improvement Committee consists of	

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(F 431) Continued From page 15

8:00a.m. She stated, "It's not affixed."

The surveyor informed the administrator and regional nurse consultant of the above concern on 2/23/17 at 10:40a.m. The regional nurse stated, "I thought that the narcotic box was affixed in the refrigerator; the pharmacy must have replaced."

No further information was provided to the survey team concerning the above issue prior to the exit conference.

(F 514) 483.75(l)(1) RES SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical document review the facility staff failed to ensure a complete and accurate clinical record for 2 of 12 Residents, Resident #210 and Resident #205.

The findings included:

(F 431)

3/13/17

at least the Administrator, Director of Nursing, Unit Managers, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director. Activity Director, Social Services Director, Therapy Services Director and the Medical Director.

(F 514)

F 514

1. Resident # 210 was assessed by the Assistant Director of Nursing on 2/22/17. No negative outcomes were identified. The Responsible Party and Physician were notified of the omissions by the licensed nurse.

Resident #205 was assessed by the Assistant Director of Nursing on 2/22/17. No negative were identified. The resident was made aware of the omissions by the licensed nurse and the physican was notified of the omissions.

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(F 514)	Continued From page 16	(F 514)		3/13/17

1. For Resident #210 the facility staff failed to accurately document treatments completed on the TAR (treatment administration record)

Resident #210 was admitted to the facility on 09/30/16. Diagnoses included but not limited to hemiplegia, atrial fibrillation, diabetes mellitus, hypertension, hyperlipidemia, dementia, anxiety, depression, and insomnia.

The most recent MDS (minimum data set) with and ARD of 12/30/16 coded the Resident as 0 out of 15 in section C, cognitive patterns. This is a quarterly MDS

Resident #210's clinical record was reviewed on 02/22/17. It contained a signed POS (physician's order summary), which read in part "Left hand roll as tolerated to decrease contracture". Resident #210's TAR's were reviewed and contained an entry which read in part "left hand roll to decrease contracture". This entry was marked with "N" on the following days and times: 02/04, 02/05, 02/10, 02/12, 02/16, 02/19 at 7am, and 02/07, 02/12, 02/13, 02/14 at 7pm. Notes in the comments section of the TAR for each of these entries read in part "left hand roll as tolerated to decrease scheduled for 02/../2017 7:00 AM/PM, not administered by assigned nsg (nursing) staff"

Surveyor spoke with RN #2 (registered nurse), who is the treatment nurse, on 02/22/17 at approximately 1620 regarding the "N" on the TAR's. RN #2 stated that she has been doing treatments since Jan 2017 and that she only works weekdays. She stated that when she went to the computer to sign for her completed treatments on Resident #210, the computer

2. All residents in house had a head to toe skin assessment completed on 2/22/17 by the Assistant Director of Nursing, the Unit Managers, and the Minimum Data Set Nurses. All residents requiring skin wound care and PICC line care were correctly identified on the TAR.

3. Licensed Nurses on were in-serviced on following treatment orders, and treatment documentation by the Assistant Director of Nursing on 2/22/17 – 3/7/17. Any Licensed Nurses not in-serviced by 3/7/17 will not be allowed to work unit the inservice education is provided.

The Unit Managers were in-serviced by the DON on checking the MAR's and TAR's daily for omissions on 2/23/17.

4. An audit of 5 treatment administration records will be conducted by the Unit Managers or designee weekly for 4 weeks. Then 3 treatment

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F 514	Continued From page 17	F 514		3/13/17

wou d not let her complete her treatments until she put something in the blank areas that had not been signed for. Stated she was worried about how it would show up, but had to put something there in order for the computer to allow her to proceed. Stated that she made a note saying treatment not administered by assigned nurse

Surveyor spoke with LPN (licensed practical nurse) #2 on 02/23/17 regarding Resident #210. LPN #2 stated that she always made sure Resident had hand roll in place when she was working. LPN #2 also stated that she did not know this was on TAR.

The concern of documenting completed treatments was discussed with the administrative team during a meeting on 02/23/17 at approximately 1040.

No further information was provided prior to exit.

2.The facility staff failed to document physician ordered treatments for Resident #205.

Resident #205 was admitted to the facility on 2/11/17, with a diagnoses that included, but were not limited to: diabetes, acute osteomyelitis right ankle and foot, diabetic foot ulcer, high blood pressure, and depression.

The initial MDS (minimum data set) assessment was incomplete. Resident #205 was alert and responsive when spoke to by the surveyor and staff.

The interim comprehensive care plan was reviewed on 2/23/17. The care plan contained focus areas for pain, osteomyelitis, and activities of daily living, cognition, incontinence, and

administration records weekly for 4 weeks. Then 1 treatment administration record weekly for 4 weeks and/or 100% compliance by the Director of Nursing. The results of the audits will be presented by the Director of Nursing to the Quality Assurance/Performance Improvement Committee for 3 months and/or until substantial compliance is achieved. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Unit Managers, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.

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(F 514)	Continued From page 18	(F 514)		3/13/17

diabetic foot ulcer

On 2/23/17, the clinical record was reviewed. The record contained a physician's order for: "Bacitracin 500 unit apply daily to sutures wound RLE (right lower extremity) cover with 4x4 and kerlex. Start date 2/11/17. No blood pressure or needle sticks RUE (right upper extremity) while PICC line is in place. Monitor RUE for s/s (signs and symptoms) of infection while PICC line is in place."

Review of the resident's treatment record revealed on 2/12/17 the Bacitracin 500 unit applied daily to sutures wound RLE cover with 4x4 and kerlex had not been documented. On 2/17/16, the order for No blood pressure or needle sticks RUE (right upper extremity while PICC line is in place. Monitor RUE for s/s of infection while PICC line is in place). There was no documentation for the orders.

A telephone interview was conducted with LPN #5 on 2/23/17 at 10:00am. She was asked if she had provided the Bacitracin daily treatment as ordered for Resident #205 on 2/12/17. LPN #5 said, "I did. I just didn't document it."

LPN #6 was interviewed at the facility on 2/23/17 and asked if she had performed the ordered treatments she told the surveyor; "I did not do the blood pressure on the arm with the PICC line, but I did not document it. I did check for s/s of infection when I flushed his PICC line. I did not document."

The administration staff and nurse consultant were notified of the above during a meeting with the survey team on 02/23/17 at approximately

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(F 514)	Continued From page 19 10:40a.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	(F 514)		3/13/17