Our Home, Our Family, Our Life, Too.

Heritage Hall of Big Stone Gap • 2045 Valley View Drive • Big Stone Gap, VA 24219 • (P) 276.523.3000

March 29, 2016

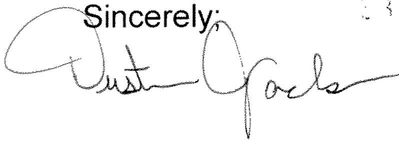
Center for Quality Health Services & Consumer Protection
Division of Long Term Care Services
9960 Mayland Drive – Suite 401
Attn: Rodney Miller, Long Term Care Supervisor
Richmond, VA 23233-1463

Mr. Miller;

Attached to this cover letter you will find Heritage Hall – Big Stone Gap's Plan of Correction and our credible allegation of compliance. The Plan of Correction addresses the corrective action, identification of deficient practices, systemic changes, and monitoring that will be implemented to address deficient practices identified during the annual survey process.

If I can be of further assistance don't hesitate to contact me at (276) 523-3000.

Sincerely,



Dustin Jackson
Administrator

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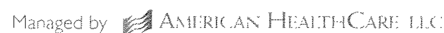

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/23/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495135	A. BUILDING ______ B. WING ______	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BIG STONE GAP	2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/8/16 through 3/10/16. Two complaints was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow The census in this 180 certified bed facility was 177 at the time of the survey. The survey sample consisted of 24 current Resident reviews (Resident #1 through Resident #24) and 4 closed record reviews (Residents #25, #26 #27, and #28)	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment, or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money	F 278	**F278** **Corrective Action(s):** Resident #8's Admission MDS with an ARD of 3/1/16 was reviewed by the MDS nurse and a modification was completed to accurately code section K0300 for a weight loss of 10% or more in 180 days on the MDS. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of all current resident assessments will be completed by the MDS nurses and/or designee to ensure that MDS section K - weight loss is assessed and coded correctly. All negative findings will be reported to the MDS nurses for immediate correction. A Modification will be completed for each discrepancy identified on the most current MDS.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 3/29/2016

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

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F 278	Continued From page 1 penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. 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 ensure a complete and accurate Minimum Data Set (MDS) assessment for 1 of 28 Residents in the sample survey, Resident #8. The Findings included: Resident #8 was a 73 year old female who was originally admitted on 9/4/13 and readmitted on 2/18/16. Admitting diagnoses included, but were not limited to: acute kidney failure, hip fracture, rheumatoid arthritis, cerebral infarct, hypertension, dementia, cerebrovascular accident and a urinary tract infection. The most current Minimum Data Assessment (MDS) located in the clinical record was a 14 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 3/1/16. The facility staff coded that Resident #8 had a Cognitive Summary Score of 3. The facility staff also coded that Resident #8 required extensive (3/3) to total nursing care (4/3) with Activities of Daily Living (ADL's). In Section K. Swallowing/Nutritional Status the facility staff coded that Resident #7 weighed 158 pounds. In Section K0300.Weight Loss-Loss of 5% or more in the last month or loss of 10% or more in the last 6 months, the facility staff coded "No or unknown." (sic) On March 9, 2015 at 12:50 p.m. the surveyor reviewed Resident #8's clinical record. Review of the clinical record revealed the following weights: 9/1/15- 185.0 pounds 10/1/15- 180.0 pounds	F 278	**Systemic Change(s):** The Resident Interdisciplinary Care Team have been inserviced by the Regional Nurse consultant on the proper assessment and coding of all areas of the MDS to include section K of the MDS. All comprehensive MDS's and quarterly MDS's will now be reviewed each week according to the MDS schedule by the MDS nurses and/or DON to ensure the accuracy and integrity of resident data. **Monitoring:** The DON and MDS nurses are responsible for monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS calendar to monitor for compliance. All negative findings from the audits will be reported to the DON and MDS nurses at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 4/5/16**	

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F 278	Continued From page 2	F 278		

11/2/15-183.0 pounds
12/1/15-175 pounds
01/1/16-168.0 pounds
2/1/16-161.0 pounds
2/18/16-158.0 pounds
3/1/16-154.0pounds

The surveyor calculated that Resident #8 had had a 16.8% weight loss (31 pounds) from 9/1/15 through 3/1/16.

On March 9, 2016 at 1:55 p.m. the surveyor notified the 2 MDS Nurse's that Resident #8's 14 Day Medicare MDS with the ARD of 3/1/16 was incorrect. The surveyor reviewed the 14 Day Medicare MDS with one of the MDS Nurse's (#1). The surveyor pointed out that Section K did not capture/code Resident #8's significant weight loss. The surveyor reviewed Resident #8's weight record with MDS Nurse (#1). The surveyor pointed out the significant weight loss within the past 180 days. The surveyor notified the MDS Nurse (#1) that the MDS with the ARD of 3/1/16 should have been coded for a significant weight loss over the past 180 day. The MDS Nurse (#1) stated that the 14 Day Medicare MDS should have been coded as a weight loss.

On March 9, 2016 at 4:20 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON) and the Corporate Compliance Nurse (CCN) that the facility staff failed to ensure a complete and accurate MDS for Resident #8. The surveyor notified the Administrative Team (AT) that Resident #8 had a significant weight loss over the past 180 days. The surveyor notified the AT that Resident #8's 14 Day Medicare MDs with the ARD of 3/1/16 did not code/capture the significant weight loss in the past 180 days.

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F 278	Continued From page 3 No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #8.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, it was determined that the facility staff failed to follow physician orders for 1 of 28 Residents in the sample survey, Resident #15. The Findings Included: Resident #15 was a 57 year old male who was admitted on 3/3/16. Admitting diagnoses included, but were not limited to: lung cancer with metastasis, anxiety, congestive obstructive pulmonary disease, depression, hypertension and osteoarthritis. Due to Resident #15 ' s recent admission, there was no Minimum Data Set (MDS) assessment available. On March 9, 2016 at 8:30 a.m. the surveyor reviewed Resident #15's clinical record. Review of the clinical record produced physician orders dated 3/3/16.Physcian orders included, but were not limited to ... "Dexamethasone 2 mg po (by mouth) TID X's (three times a day) (for) 5 Days. Stop Date: 3/10/16." (sic) Continued review of the clinical record produced	F 309	**F309** **Corrective Action(s):** Resident #15's attending physician was notified that the facility failed to administer Dexamethasone as ordered by the attending physician. A facility Incident and Accident form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents may have been potentially affected. The DON, ADON, and Unit Managers will conduct a 100% audit of all resident's physician orders and MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.	

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F 309	Continued From page 4 the March 2016 Medication Administrative Records (MAR's). Review of the March 2016 MAR's documented that the Dexamethasone 2 mg was not administered on 3/7/16. The facility staff documented that the Dexamethasone was not administered at 1 p.m. The notes stated that the "criteria was not met" to administer the Dexamethasone. On March 8, 2016 at 9:45 a.m. the surveyor notified the Director of Nursing (DON) and Corporate Compliance Nurse (CCN) that the facility staff did not administer the Dexamethasone 2 mg on 3/7/16 and 1 p.m. as ordered by the physician. The surveyor reviewed the clinical record with the DON and CCN. The surveyor pointed out the specific order for the Dexamethasone 2 mg by mouth three times a day. The surveyor then reviewed the March 2016 MAR's with the DON and CCN. The surveyor notified the DON and CCN that the Dexamethasone did not have any special physician ordered criteria to administer or hold the Dexamethasone. On March 9, 2016 at 4:20 p.m. the survey team met with the Administrator (Adm), DON and CCN. The surveyor notified the Administrative Team (AT) that the facility staff held/did not administer the physician ordered Dexamethasone 2 mg on 3/7/16 at 1 p.m. on Resident #15. The surveyor notified the AT that the staff documented that the "criteria was not met" to administer the medication. The surveyor notified the AT that no specific criteria was identified in the physician order to administer or hold the Dexamethasone. No additional information was provided as to why the facility staff failed to follow physician orders for Resident #15.	F 309	**Systemic Change(s):** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record / physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician medication orders & treatment orders. The DON and/or Regional nurse consultant will inservice all licensed staff on the procedure for obtaining, transcribing, and completing physician ordered medication and treatment orders. **Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will audit/review all MAR's weekly to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 4/5/16**	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		

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F 333 Continued From page 5

The facility must ensure that residents are free of any significant medication errors.

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 ensure that 1 of 28 Residents in the sample survey was free from Significant medication errors, Resident #15.
The Findings Included:
Resident #15 was a 57 year old male who was admitted on 3/3/16. Admitting diagnoses included, but were not limited to: lung cancer with metastasis, anxiety, congestive obstructive pulmonary disease, depression, hypertension and osteoarthritis.
Due to Resident #15's recent admission, there was no Minimum Data Set (MDS) assessment available.
On March 9, 2016 at 8:30 a.m. the surveyor reviewed Resident #15's clinical record. Review of the clinical record produced an Insulin Sliding Scale Protocol, signed and dated by the physician on 3/4/16. The sliding scale protocol ordered for Resident #15 to receive Humalog sliding scale. The physician ordered for Resident #15 to receive 6 Units of Humalog Insulin for blood sugars 261-300.
Continued review of the clinical record produced the March 2016 Medication Administrative Records (MAR's). Review of the March 2016 MAR's documented that Resident #15's blood sugar was 283 on March 4, 2016 at 7:30 a.m. The March 2016 MAR's also documented that the facility staff administered 10 Units of Humalog Insulin. Resident #15 should have received 6 Units of Humalog Insulin.
On March 9, 2016 at 9:45 a.m. the surveyor notified the Director of Nursing (DON) and

F 333

F333
Corrective Action(s):
Resident #15's attending physician has been notified that the facility failed to administer Humalog Sliding scale insulin per physician order. The nurse involved in the medication error has received one-on-one inservice training from the DON on the administration of physician ordered medications. A facility Incident & Accident form was completed for each incident.

Identification of Deficient Practice(s) and Corrective Action(s):
All other residents receiving diabetic medications may have potentially been affected. A 100% review of all residents with sliding scale insulin orders was conducted to identify residents at risk. All residents identified at risk will be corrected at time of discovery and appropriate disciplinary action taken. An Incident and Accident form will be completed for each negative finding.

Systemic Change(s):
The facility policy and procedure has been reviewed and no changes are warranted at this time. All Licensed staff will be inserviced on the facility policy and procedure by the DON regarding the administration of medications per physician orders to include the proper administration of sliding scale insulin as ordered by the physician.

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F 333	Continued From page 6 Corporate Compliance Nurse (CCN) that the facility staff did not administer the correct dose of sliding scale Humalog Insulin on 3/4/16 at 7:30 a.m. The surveyor reviewed Resident #15's clinical record with the DON and CCN. The surveyor reviewed the specific physician ordered Humalog sliding scale protocol. The surveyor then reviewed the March 2016 MAR's with the DON and CCN. The surveyor pointed out that Resident #15's blood sugar was 283 on 3/4/16 at 7:30 a.m. The surveyor pointed out that the facility staff administered 10 Units of Humalog Insulin. The surveyor pointed out that the facility staff should have administered 6 Units of Humalog Insulin. On March 9, 2016 at 4:20 p.m. the survey team met with the Administrator (Adm), DON and CCN. The surveyor notified the Administrative Team (AT) that the facility staff failed to follow physician orders for the administration of Humalog sliding scale Insulin. The surveyor notified the AT that the facility staff administered 10 Units of Humalog Insulin, when in fact; they should have administered 6 Units of Humalog sliding scale Insulin. No additional information was provided as to why the facility staff failed to ensure that Resident #15 was free from significant medication errors.	F 333	**Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON and/or designee will do weekly MAR audits to monitor for compliance. Any negative findings will be addressed at the time of discovery and appropriate disciplinary action taken. Detailed findings of these results will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 4/5/16**	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services	F 425		

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F 425 Continued From page 7

(including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This Requirement is not met as evidenced by:
Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to ensure that physician ordered medications were available for administration for 1 of 28 Residents in the sample survey, Resident #15.
The Findings Included:
Resident #15 was a 57 year old male who was admitted on 3/3/16. Admitting diagnoses included, but were not limited to: lung cancer with metastasis, anxiety, congestive obstructive pulmonary disease, depression, hypertension and osteoarthritis.
Due to Resident #15 ' s recent admission, there was no Minimum Data Set (MDS) assessment available.
On March 9, 2016 at 8:30 a.m. the surveyor reviewed Resident #15's clinical record. Review of the clinical record produced physician orders dated 3/3/16. Physician orders included, but were not limited to the following: "Sertraline HCL 100mg 1 tab (tablet) po (by mouth) q day (everyday) DX (diagnoses) depression, Levofloxacin 750 mg tablet give 1 tab q day X's (times) 7 days discontinue date 3/10/16, Dexamethasone 4 mg po BID (twice daily)

F 425

F425
Corrective Action(s):
Resident #15's attending physician has been notified that the facility failed to ensure that physician ordered medications Sertraline HCL 100mg, Levofloxacin 750mg, Dexamethasone 4 mg and Gabapentin 300mg were available from pharmacy for administration to Resident #15. A facility Incident and Accident form has been completed for this incident.

Identification of Deficient Practices & Corrective Action(s):
All residents may have potentially been affected. A 100% review of all resident's medication regimes has been conducted by the DON, ADON and/ or Unit manager to identify residents at risk. Residents found to be at risk due the medication being unavailable from the pharmacy will be corrected at time of discovery and their attending physicians will be notified. A facility Incident and Accident form has been completed for each.

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F 425	Continued From page 8 through 3/5/16 Stop date 3/05/16 and Gabapentin 300 mg capsule give 1 cap (capsule) po BID." (sic) Continued review of the clinical record produced the March 2016 Medication Administrative Records (MAR's). Review of the March 2016 MAR's documented that Resident #15's did not receive the Sertraline HCL 100mg, Levofloxacin 750 mg, Dexamethasone 4 mg and the Gabapentin 300 mg on 3/4/16 at 9 a.m. The facility staff documented on the March 2016 MAR's that the medications were not available from the pharmacy. On March 9, 2016 at 9:45 a.m. the surveyor notified the Director of Nursing (DON) and Corporate Compliance Nurse (CCN) that Resident #15 did not receive physician ordered medications on 3/4/16. The surveyor reviewed the clinical record with the DON and CCN. The surveyor reviewed Resident #15's physician orders with the DON and CCN. The surveyor then reviewed the March 2016 MAR's with the DON and CCN. The surveyor pointed out that the facility staff documented that the physician ordered medications were not available from the pharmacy. The surveyor asked the DON and CCN if the facility had a backup pharmacy and the DON named a local pharmacy. The surveyor requested a copy of the facility policy and procedure for obtaining medications. On March 9, 2016 at 4:20 p.m. the survey team met with the Administrator (Adm), DON and CCN. The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure that physician ordered medications were available for administration for Resident #15. On March 10, 2016 at 7:30 a.m. the surveyor reviewed the facility policy and procedure titled, "Receipt of Interim/Stat/Emergency Deliveries," that had been left on the table in the conference	F 425	**Systemic Changes:** The Pharmacy Policy and Procedure has been reviewed and no changes are. warranted. All licensed nursing staff have been inserviced on the Policy and Procedure for medication administration to included medications that are unavailable or do not arrive at the facility timely from the pharmacy. The inservice will include the steps the nurse should take should a medication not be delivered timely from the pharmacy. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will conduct medication reviews of resident medication orders each week coinciding with the Care plan calendar to check for the availability of all ordered drugs. All negative findings will be corrected at the time of discovery. Results of the reviews will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 4/5/16**	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495135	A. BUILDING ______ B. WING ______	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BIG STONE GAP	**2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219**

(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 425	Continued From page 9 room. The policy and procedure read in part ... "Procedure 1. The Facility should immediately notify the Pharmacy when the Facility receives from a prescriber a medication order that may require an interim/stat/emergency delivery. 2. If a necessary medication is not contained within the Facility's interim/stat/emergency supply, and it is determined that an interim/stat/emergency delivery is indicated, the Facility should either: 2.1 Arrange with the Pharmacy to include the interim/stat/emergency medication(s) in an earlier scheduled delivery or a special delivery, or arrange for delivery by contract courier; or 2.2 Arrange for the medication to be dispensed and delivered by a Third Party Pharmacy." No additional information was provided as to why the facility staff failed to ensure that physician ordered medications were available for administration for Resident #15.	F 425		
F 513 SS=D	483.75(k)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. 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 ensure that physician ordered X-rays results were in the clinical record for 1 of 28 Residents in the sample survey, Resident #3. The Findings Included: Resident #3 was an 82 year old female who was admitted on 2/1/16. Admitting diagnoses included, but were not limited to: thoracic 11 and 12 vertebra fractures, pressure ulcer on sacrum, hypothyroidism, depression, obesity, atrial fibrillation, breast cancer, failure to thrive and a	F 513	**F513** **Corrective Action(s):** Resident #3's attending physician has been notified that the results of a physician ordered X-ray for a thoraclumbar X-ray were not available in the resident medical record. A Facility Incident & Accident form has been completed for missing diagnostic test results.	

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F 513	Continued From page 10 femur fracture. The most current Minimum Data Set (MDS) located in the clinical record was a 30 Day Medicare MDS with an Assessment Reference Day (ARD) of 2/29/16. The facility staff coded that Resident #3 had a Cognitive Summary Score of 14. The facility also coded that Resident #3 required extensive assistance (3/3) with Activities of Daily Living (ADL's). On March 8, 2016 at 1:30 p.m. the surveyor made the initial tour of the facility with a Registered Nurse (RN). The RN informed the surveyor that Resident #3 had fractures in her back and that the facility had recently discontinued the back brace that Resident #3 had been required to wear. On March 9, 2016 at 8:45 a.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record a Physician Telephone order dated 3/2/16. The physician telephone order read in part ... "Canceled X-ray of thoracolumbar spine @ (at) (name of vendor withheld) 10 am on 3/5/16 s/t closed. ? (change) to 3/4/16 @ 10am." (sic) Additional review of the clinical record failed to produce the results of the physician ordered X -Ray of the thoracolumbar spine on 3/4/16. On March 9, 2016 at 9:05 a.m. the surveyor notified a Licensed Practical Nurse (LPN #5) that Resident #3 had a physician order to obtain an X-Ray of the thoracolumbar spine on 3/4/16. The surveyor notified LPN (#5) that the results of the physician ordered X-Ray was not in the clinical record. The surveyor reviewed the clinical record with LPN (#5). The surveyor pointed out the specific physician order for the X-Ray of the thoracolumbar spine. LPN (#5) reviewed the clinical record and was unable to locate the results of the physician ordered X-Ray. LPN (#5) stated that Resident #3 had gone out of the	F 513	**Identification of Deficient Practices & Corrective Action(s):** All other residents with physician ordered X-rays or diagnostic test may have potentially been affected. A 100% review of all resident medical records will be conducted by the Unit Mangers, Medical Records and/or designee to identify residents at risk.A Risk Management Incident & Accident Report will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. Licensed staff will be inserviced by the DON on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include timely and accurate filing of laboratory test results, X-ray and Diagnostic test results according to the acceptable professional standards and practices. **Monitoring:** The DON is responsible for maintaining compliance. The DON, and/or designee will complete lab/diagnostic test audits weekly to monitor for complaince. Any/all negative findings will be corrected at time of discovery. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 4/5/16**	

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F 513	Continued From page 11 facility to get the X-Ray done. The surveyor notified LPN (#5) that the results should be contained in the clinical record. LPN (#5) stated she would attempt to find the results of the physician ordered X-Ray. On March 9, 2016 at 9:45 a.m. the Corporate Compliance Nurse (CCN) hand delivered the results of the physician ordered thoracolumbar spine X-ray. The findings read in part ... "There is a moderate compression deformity of T12 again demonstrated. The vertebral body has lost approximately 50% of its height. The posterior are wall remains intact. The T12 ribs are hypoplastic. There is mild-to-moderate degenerative disc disease at L3-4 and L4-5 and there is mild disc disease at L2-3." (sic) On March 9, 2016 at 4:20 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON) and CCN. The surveyor notified the Administrative Team (AT) that Resident #3 had a physician order to obtain a thoracolumbar spine X-Ray on 3/4/16. The surveyor notified the AT that the results of the physician ordered X-Ray was not contained in the clinical record. No additional information was provided as to why the facility staff failed to ensure that the results of the physician ordered X-Ray was not contained in the clinical record.	F 513		

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